Paint Valley Crisis System Assessment and Recommendations

Paint Valley ADAMH Board

June 2022

TBD Solutions LLC
2930 Lucerne Dr SE
Grand Rapids, MI 49546

Table of Contents

©TBD Solutions LLC

Executive Summary

In 2021, the Paint Valley Alcohol, Drug Abuse, and Mental Health (PVADAMH) Administration Board contracted with TBD Solutions to conduct a comprehensive assessment of the region's crisis continuum and provide recommendations for developing, enhancing, and sustaining behavioral health crisis services.

During each month of the project, TBD Solutions convened crisis system community meetings and engaged a variety of methods outlined in the figure below for assessing the behavioral health crisis system.

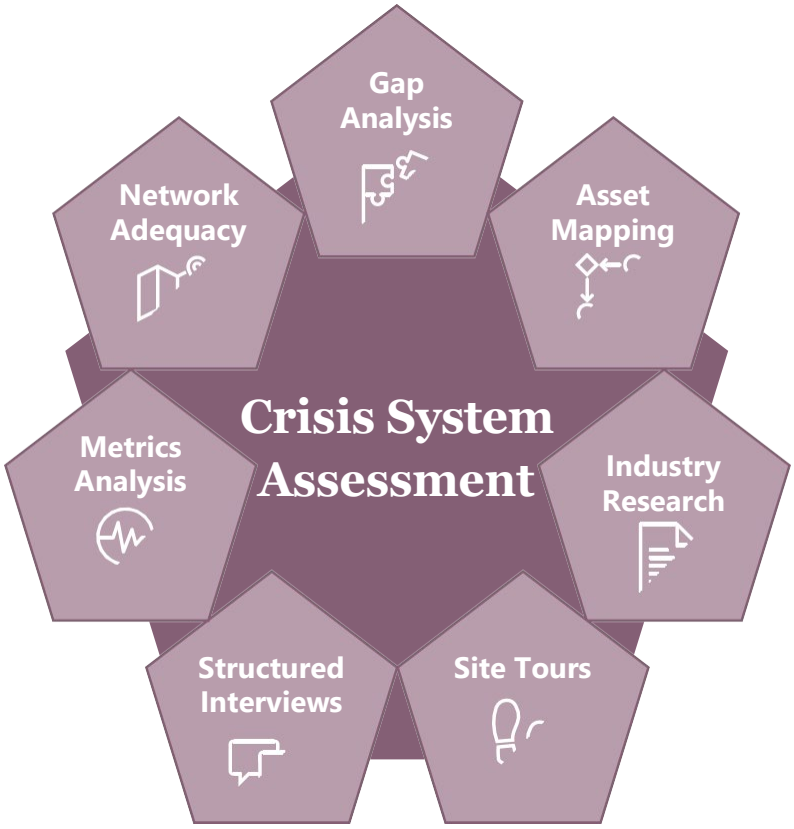


Figure 1

Overall strengths of the *Paint Valley behavioral health* crisis continuum include their desire to be collaborative, their tangible efforts to improve the current system, and the creative solutions they've crafted to address gaps in youth services. Weaknesses of the system include lack of essential crisis services and poor data collection and reporting, resulting in a lack of meaningful metrics and key performance indicators.

Based on a comprehensive assessment of the current system, review of data, input from community stakeholders, and consideration of best practices for an effective crisis continuum, TBD Solutions makes the following recommendations:

1. **Expand crisis services and capacity** by developing a six-chair, 23-hour crisis observation unit, a six-bed crisis stabilization unit, and five total adult and youth mobile crisis teams

2. **Improve care coordination** by increasing communication, collaboration, and creating standardized processes for assessment, admission criteria, and discharge.
3. **Develop outcomes driven care** by providing satisfaction surveys, tracking monthly utilization data, and convening bi-monthly stakeholder meetings to review data and develop regional benchmarks.

An effective crisis services continuum provides an individual in crisis a clear pathway for accessing care and options for how to best address their behavioral health crisis, many of which are community-based. A comprehensive crisis continuum allows a community to ensure the best fit clinically to support the individual in crisis while also addressing issues of safety, choice, and personal freedom. Following the recommendations set forth will result in the expansion of high-quality sustainable crisis services that are informed by data and strengthen care coordination efforts in the region.

Introduction

As the behavioral health authority for Pike, Fayette, Highland, Pickaway, and Ross Counties in southern Ohio, the Paint Valley Alcohol, Drug Abuse, and Mental Health (ADAMH) Services Board (referred to as "Paint Valley ADAMH Board") is responsible for planning, funding, and monitoring the public system of care for individuals who are indigent, uninsured, or under-insured and experience mental health and/or substance use disorders. The region has a combined population of 235,573.[1]

In October 2021, the Paint Valley ADAMH Board contracted with TBD Solutions to conduct a comprehensive assessment of the region's crisis continuum and provide recommendations for developing, enhancing, and sustaining behavioral health crisis services.

Considerations

Persons Served

Individuals receiving behavioral health treatment are referred to by many different names, including patient, client, consumer, resident, guest, individual, and person served. This report is predicated upon the foundation of recovery-oriented principles in mental health treatment and choosing the least stigmatizing language. While TBD Solutions understands the potential breadth and diversity of this report's audience, the language "client" or "person served" will be used when referring to a person receiving services as it is universally understood and less stigmatizing than words like "patient" or "consumer."

Methods & Findings

TBD Solutions engaged a multifaceted approach to assessment and analysis of the current behavioral health landscape in the five-county region inclusive of Fayette, Highland, Pickaway, Pike, and Ross Counties in southern Ohio.

Community Collaborative

The **Paint Valley ADAMH Crisis System Collaborative** convened five times over the course of six months, both virtually and in-person. Thirty-four community stakeholders participated, representing 18 organizations throughout the region, including leaders and providers from the Paint Valley Board, behavioral health providers, hospital systems, school systems, law enforcement, and persons with lived experience in the behavioral health system.

The Crisis System Collaborative convened to meet the following agreed upon goals:

- Review current practices related to the functioning of existing behavioral health crisis services for adults and youth in the Paint Valley region

[1] United States Census Bureau. (2021). *QuickFacts*. https://www.census.gov/quickfacts/fact/table/pikecountyohio,fayettecountyohio,highlandcountyohio,pickawaycountyohio,rosscountyohio/PST045221

- Provide clear avenues for communication between organizations throughout the Paint Valley region specific to availability of behavioral health services and access

- Make recommendations to improve intervention, treatment, and support services for adults and youth experiencing psychiatric emergencies

- Make recommendations regarding potential funding opportunities for recommended programs and services

Gap Analysis

Communities with lower population density sometimes lack the volume needed to support and sustain a full range of crisis services. Each county within the Paint Valley region presents a unique set of needs and considerations based on its geographic location and cultural features among countless additional factors, as described in the network adequacy section of this report.

While some variation is expected based on community needs, published best practice recommendations serve as a benchmark for building and enhancing local crisis networks. Two primary sources informed the gap analysis: *The Roadmap to the Ideal Crisis System*[2] (2021) and *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit*[3] (2020). The gap analysis considers the features of a best practice crisis network and compares those features with the programs and characteristics identified within each county's crisis network. Based on this comparison, disparities have been identified for consideration and potential resolution.

Asset Mapping

The Paint Valley region is made up of a network of community partners and providers delivering behavioral health care to individuals with behavioral health crises in Fayette, Highland, Pickaway, Pike, and Ross Counties. While these partners have various missions, funding sources, and oversight, they can be conceptualized as a single, complex crisis network inclusive of adult and youth services. Within the Paint Valley region, this crisis network comprises four distinct types of providers, each of which may exist at multiple locations. Provider types include:

[2] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). *Roadmap to the Ideal Crisis System.* (pp. 1–209). National Council for Behavioral Health. https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf.

[3] Substance Abuse and Mental Health Services Administration. (2020). (rep.). *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* (pp. 1–80). SAMHSA. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Hospital/ Emergency Department

Mental Health Provider

Law Enforcement

Substance Use Providers

Miscellaneous

TBD Solutions facilitated an asset mapping exercise to best understand how this array of service providers interacts with one another and to identify areas for improvement. Paint Valley ADAMH Board and Scioto Paint Valley Mental Health Center, the primary crisis provider for the region, were the primary participants. The exercise mapped the interfaces and stress points between community assets and resources while answering the following questions:

1. What types of providers are currently part of each county's crisis network?
2. How do these providers interact with one another during acute behavioral health crises?

The following components were analyzed for each county within the Paint Valley region.

- The **network graphs** (Figures 2-6) illustrate the relationships of assets and connections identified between its members. The size of the circle is relative to the number of connections, both incoming and outgoing, that provider is mapped to.
- Service providers with only an extensive number of **incoming connections** are likely to be delivering crisis resolution services. Within the behavioral health continuum, they likely make outgoing referrals; however, in the context of the crisis network the crisis is resolved and no further connections need to be made
- Service providers with only an extensive number of **outgoing connections** are likely to be either the first response to crisis needs or the authorizing body for crisis service delivery. Within the behavioral health continuum, they may provide other services; however, within the crisis network they are primarily connecting individuals served to providers who deliver the direct crisis-resolution services.
- Service providers connected within the network with a high number of **incoming and outgoing connections** are especially vital to efficient flow throughout the system. They are commonly involved in navigating the network without providing crisis services.
- To better understand the **impact of a provider's incoming and outgoing referrals** within the network the influence of a particular node (e.g., provider) was evaluated using a measure called *eigenvector centrality*. In general, the measure illustrates the node's overall connectivity within the network; inclusive of first-, second-, and third-degree connections. A higher value indicates that a particular provider is connected to many providers who themselves have high scores. This perspective allows for a view of inter-network connectivity, as opposed to a view of persons served in any location.

Ross County

Network Graph

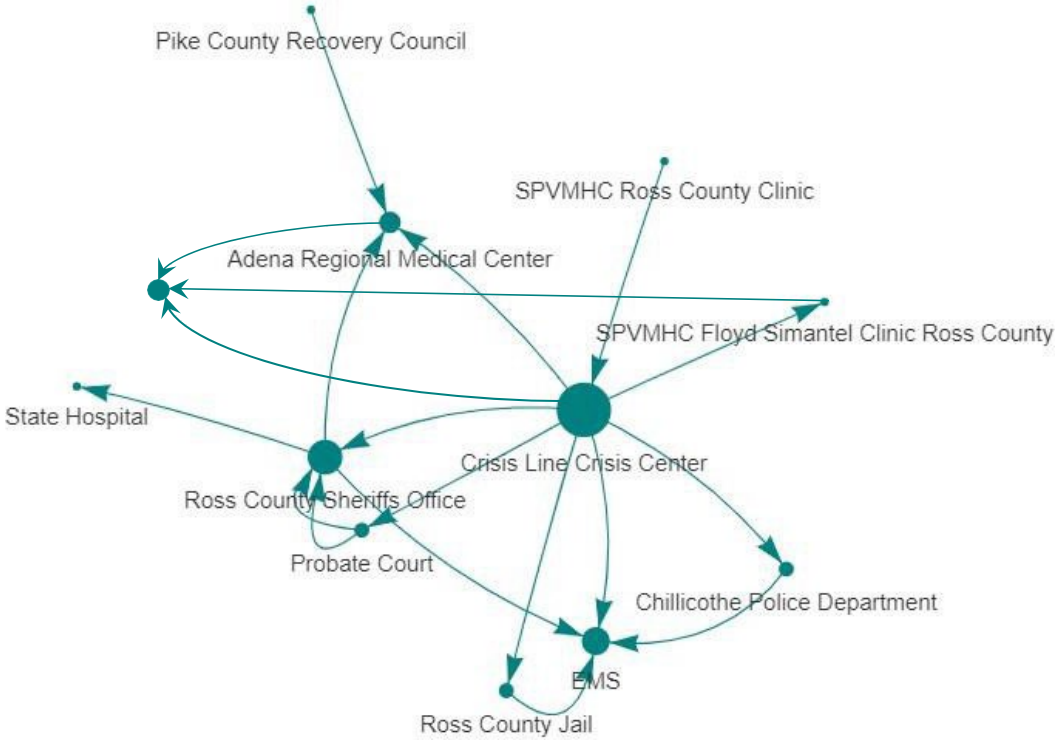


Figure 2

In Ross County, 19 distinct connections were identified within the crisis network. It is important to note that the paths identified do not signify actual utilization, rather they are representative of possible paths based on the structure of the network.

Ross County has a markedly less complex crisis network as compared to the other four counties within the region, a notable outlier as Ross County is the population center of the region. Through asset mapping and other methods TBD Solutions observed that a crisis episode originating in Ross County resulted in the fewest number of transfers throughout the journey for a person served.

The Ohio Department of Mental Health and Addiction Services, as cited in the Ohio Crisis Services Compendium, agrees with the values set forth by SAMHSA indicating that safety is a top priority during a crisis episode. Interventions should avoid harm by considering the risks and benefits of specific interventions. The system should be designed to establish feelings of personal safety and security for the individual in crisis.[4] The crisis continuum in Pike, Pickaway, Highland, and Fayette

[4] DeWine, M., Criss, L. (October 2019). Crisis Services Compendium. (pp. 1-32). Ohio Department of Mental Health and Addiction Services. https://mha.ohio.gov/wps/wcm/connect/gov/67cc56fe-c3e9-4a45-91ca-3c5e85eb145d/CrisisCompendium-web.pdf?MOD=AJPERES&CVID=nNSGFfJ

County is not designed to prioritize safety and security for persons served to the same degree as Ross County's continuum is designed. A regional approach requires persons served to be transported from their communities for assessment, allowing for increased risk during numerous transfers.

Incoming & Outgoing Connections

In mapping the crisis network, various providers had both incoming and outgoing connection points within the network, while others had connection in only a single direction. The provider with the highest number of incoming connections in Ross County is the EMS system (4), followed by Adena Regional Medical Center (3), and the Ross County Sheriff's Office (2).

The Ross County Crisis Center has the most outgoing connections within the county (7), followed by the Ross County Sheriff's Office (3).

Eigenvector Centrality

The Ross County Crisis Center and Ross County Sheriff's Office are the most central providers to the crisis network, indicating they are both key players in Ross County's crisis network.

Pike County

Network Graph

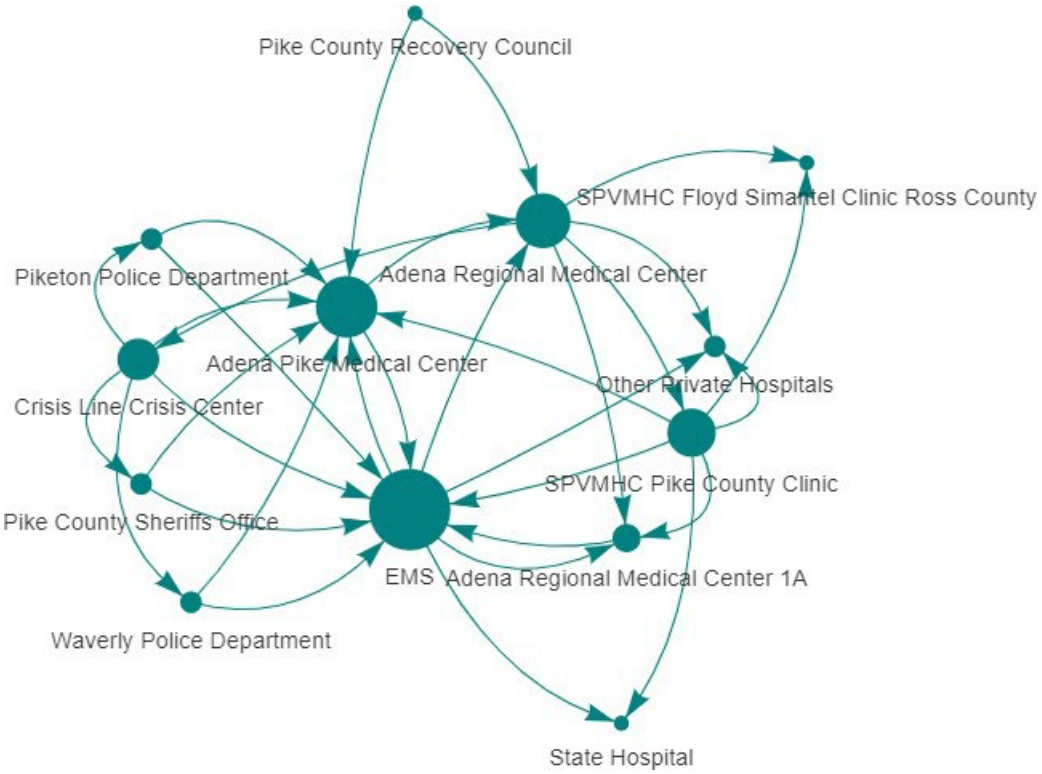


Figure 3

In Pike County 32 distinct connections were identified within the crisis network. Within the connections there are 90 possible pathways in which a person served can take as they navigate the crisis network.

Incoming & Outgoing Connections

Adena Pike Medical Center (7) and EMS (7) have the highest number of incoming connections throughout the crisis network. Providers with the most outgoing connections include the Pike County Clinic (6), Adena Regional Medical Center (5), Crisis Line (5), and EMS (5).

Eigenvector Centrality

EMS is the provider most central to the flow of the crisis network within Pike County, followed by Adena Pike Medical Center, and Adena Regional Medical Center.

Pickaway County

Network Graph

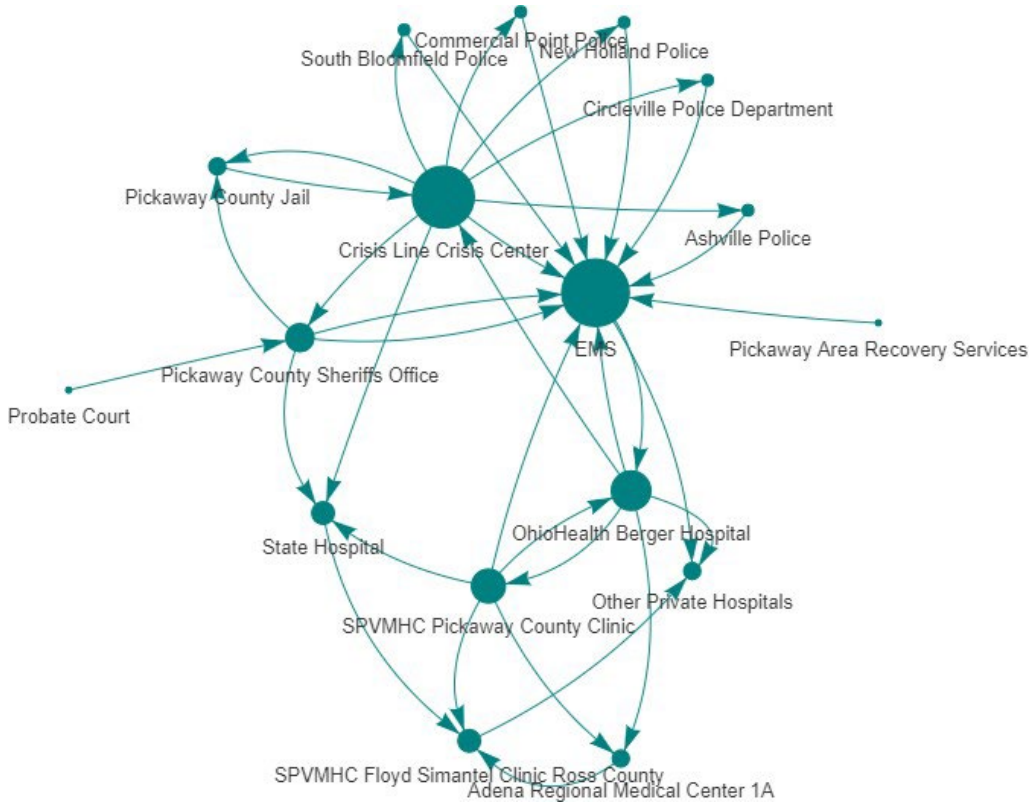


Figure 4

In Pickaway County 36 distinct connections were identified within the crisis network. Within the connections there are 132 possible pathways in which a person served can take as they navigate the crisis network.

Incoming & Outgoing Connections

EMS has the most incoming connections throughout the crisis network (10), followed by Floyd Simantel Center (3), state hospitals (3), and private hospitals other than 1A (3). The Crisis Line has the most outgoing connections (9), followed by OhioHealth Berger Hospital (5), and the Pickaway County Clinic (5). Outliers with very few incoming or outgoing connections include all of the police departments as well as probate court.

Eigenvector Centrality

In Pickaway County the providers most central to flow and connectivity within the crisis network include EMS, the Crisis Line, and OhioHealth Berger Hospital.

Highland County

Network Graph

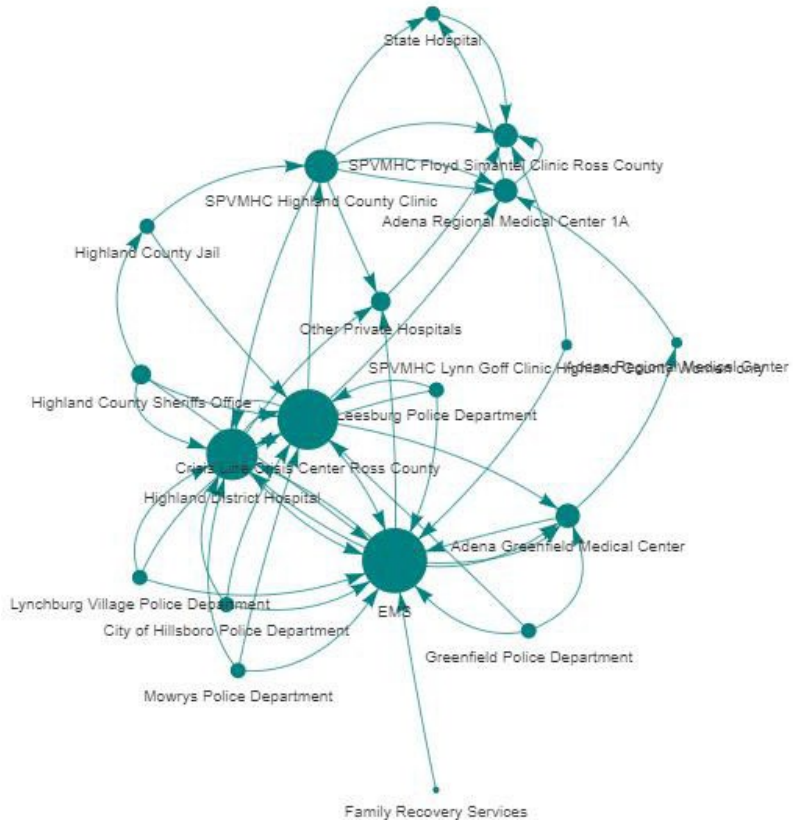


Figure 5

In Highland County 50 distinct connections were identified within the crisis network. Within the connections there are 203 possible pathways in which a person served can take as they navigate the crisis network.

Incoming & Outgoing Connections

EMS (11), Highland District Hospital (8), and the Crisis Line (8) have highest number of incoming connections in the crisis network. Conversely, the highest number of outgoing connections are the Highland County Clinic (5) and the Crisis Line (5). In Highland County the Crisis Line has a high number of incoming and outgoing connectivity, making it especially vital to efficient flow throughout the system.

Eigenvector Centrality

As indicated, the Crisis Line is central to the flow and connectivity of the crisis network within Highland County. Joined by the Crisis Line are EMS and Highland District Hospital.

Fayette County

Network Graph

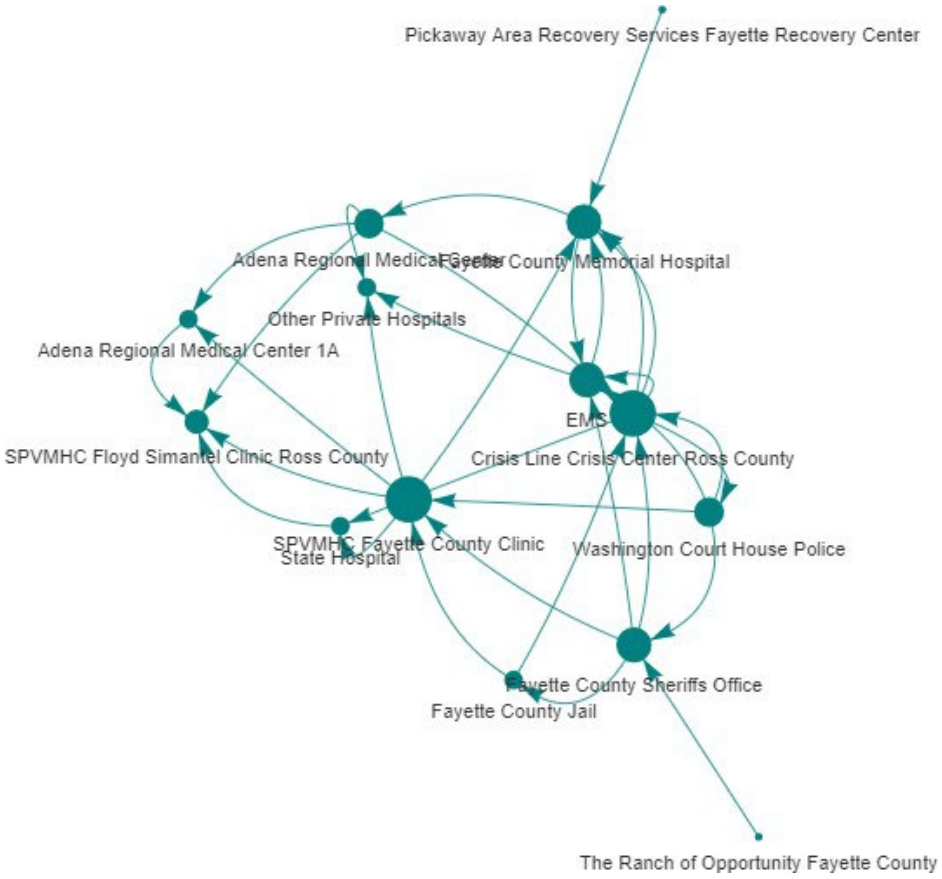


Figure 6

In Fayette County 32 distinct connections were identified within the crisis network. Within the connections there are 122 possible pathways in which a person served can take as they navigate the crisis network.

Incoming & Outgoing Connections

Four providers within Fayette County's crisis network have the highest number of incoming connections, including Floyd Simantel Clinic (4), EMS (4), Fayette County Memorial Hospital (4), and the Crisis Line (4). The Fayette County Clinic has the most outgoing connections (5).

Eigenvector Centrality

The Crisis Line and EMS are the most centrally connected provider within the crisis network in Fayette County. Fayette County presented as unique within the region with the addition of a police department, specifically the Washington Court House Police, as scoring the third highest for eigenvector centrality throughout the county.

Research

Community-based behavioral health crisis services boast a 40+ year history of achieving Triple Aim[5] health care objectives of strong clinical outcomes, high client satisfaction, and low costs compared to its medical/inpatient contemporaries.

23- Hour Observation Research

Research on treatment alternatives to the Emergency Department is limited but promising. Psychiatric emergency services such as 23-Hour Observation Units and Psychiatric Urgent Care centers have been shown to reduce Emergency Department boarding time and reducing the need for inpatient psychiatric hospitalization.[6] Research also demonstrates improvements in symptom severity, stress, psychosocial functioning, and satisfaction with care.[7]

Crisis Stabilization Unit Research

Over 30 research studies dating back to the 1970's support the efficacy and cost-effectiveness of Crisis Stabilization Units, referred to here as Crisis Residential Programs (CRPs).[8] In one study, clients reported higher satisfaction compared to inpatient psychiatric hospitalization.[9]

---

[5] Institute for Healthcare Improvement. (2022). IHI Triple Aim Initiative. IHI. http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[6] Zeller, S., et al, A. Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments. Western Journal of Emergency Medicine. Feb. 2014

[7] Sunderji, et al. Urgent Psychiatric Services: A Scoping Review. Canadian Journal of Psychiatry. Sept. 2015.

[8] To view a research overview of alternatives to hospitalization from 1973-2013, visit https://www.crisisresidentialassociation.org/crisis-residential-research-summary.html

[9] Adams, C. and El-Mallakh, R. "Patient Outcome After Treatment in a Community-Based Crisis Stabilization Unit." Journal of Behavioral Health Services, July 2009.

By keeping their average length of stay at or below the level of inpatient psychiatric hospitals, CRPs keep total treatment costs lower.[10] Cost savings are also actualized by utilizing CRPs as step-downs from inpatient hospitalization, shortening the length of stay for overall treatment.[11]

Despite the unlocked and homelike environment, CRPs have even demonstrated the ability to effectively serve individuals receiving court-ordered treatment.[12]

Mobile Crisis Research

Mobile crisis services originated in the United States in the 1960s as a community-based service, offering an alternative to psychiatric hospitalization. According to the 2020 report on mobile crisis teams, "the deinstitutionalization movement, combined with nationwide cuts in funding for inpatient hospitalization and a philosophical shift in perceptions of effective treatment delivery, motivated the consideration of community-based alternatives for hospital-based psychiatric emergency services". [13]

The article 'Erica Chestnut-Ramirez on Mobile Crisis as the First Responders of Behavioral Health'[14] states, "mobile crisis teams in Arizona have a 75-80% stabilization rate." The response time of mobile crisis teams in Maricopa County, Arizona average 30-35 minutes, compared to the average emergency system response time of 45 minutes. The ability of a mobile crisis team to rapidly respond and successfully stabilize individuals in their community means those experiencing a behavioral health crisis do not have to unnecessarily interface with other parts of the system such as law enforcement. In 2016, the system in Maricopa County served approximately 22,000 individuals and generated an approximate savings of $260 million in hospital spending, $37 million in ED spending, 45 years of ED psychiatric boarding hours, and 37 full-time equivalents of police officer time and salary.[15]

---

[10] Fenton, W. et al. "Cost and Cost-Effectiveness of Hospital vs Residential Crisis Care for Patients Who Have Severe Serious Mental Illness." Archives of General Psychiatry, 2002.

[11] Budson, R. "Community residential and partial hospital care: low-cost alternative systems in the spectrum of care." The Psychiatric Quarterly, 1994.

[12] Greenfield, T. "A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis." American Journal of Community Psychology, September 2008.

[13] IACP/UC Center for Police Research and Policy. (2020). *Assessing the Impact of Mobile Crisis Teams: A Review of Research-Academic Training to Inform Police Responses Best Practice Guide* (pp. 1-80). https://www.theiacp.org/sites/default/files/IDD/Review of Mobile Crisis Team Evaluations.pdf

[14] Crisis Now-Crisis Talk. (2020). *Erica Chestnut-Ramirez on Mobile Crisis as the First Responders of Behavioral Health* Erica Chestnut-Ramirez on Mobile Crisis as the First Responders of Behavioral Health - #CrisisTalk (crisisnow.com)

[15] Broadway, E., Covington. (2018). A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness. Alexandria, VA. National Association of State Mental Health Program Directors.

Site Tours

Visiting behavioral health treatment sites and community settings provides an invaluable opportunity to understand nuances and unique regional characteristics, observing the physical space, program layout, atmosphere, and workflows. Site tour locations are included in Figure 7.

Floyd Simantel Clinic & Ross County Partial Hospitalization Program

Adena Regional Medical Center's 14-bed Inpatient Behavioral Health Unit

Scioto Paint Valley Mental Health Center's Crisis Center

Figure 7

Structured Interviews

TBD Solutions interviewed ten providers and stakeholders within the Paint Valley region. Virtual interviews included a consistent series of questions pertaining to program operations, system design and function, care coordination, strengths, satisfaction of services, use of data in crisis services, and challenges experienced by providers and persons served. Interviewers sought to obtain a balance between objective data about service design and function and experiential information about service provision, care coordination, and community partnerships. Interview participants provided additional follow-up information when requested.

Virtual interviews included:

- Family Resource Center
- Floyd Simantel Clinic
- Haven House of Pickaway County, Inc.
- Highland District Hospital
- Mother of person served within the behavioral health crisis continuum
- OhioHealth Berger Hospital
- Pickaway County Educational Service Center
- Pickaway County Sheriff's Office
- Scioto Paint Valley Mental Health Center

Metrics Review

A strong metrics portfolio allows for greater transparency and accountability between payers, providers, and persons served in a behavioral health crisis. TBD Solutions requested data from Scioto Paint Valley Mental Health Center, Paint Valley ADAMH Board, Highland District Hospital,

and Adena Regional Medical Center. Data was requested specific to service utilization, referrals, and quality of care. Analysis was limited due to the lack of comprehensive data available. The development of outcomes-driven care is discussed more within the recommendations provided later in the report.

Utilization Data

Adena Health System

Adena Health System serves south central and southern Ohio across 38 sites ranging from wellness centers, urgent cares, primary care clinic, and emergency rooms. Adena Regional Medical Center provided the metrics below representing individuals who presented to Adena Regional Medical Center emergency department in Ross County. It is notable that individuals may have attempted to receive services at another Adena site outside Ross County, such as Adena Pike Medical Center, and were transferred via Emergency Medical Services (EMS) to the Ross County site. The seemingly convoluted system of referrals does little to benefit the person served as they are often sent to multiple locations until their crisis episode can adequately be addressed.

Data from 2019-2021 was reviewed by age group, 18 years-old and older, and 17 years-old and younger. Annual presentations ranged from 1,700 in 2019 to 1,853 in 2021, as shown in Figure 8.

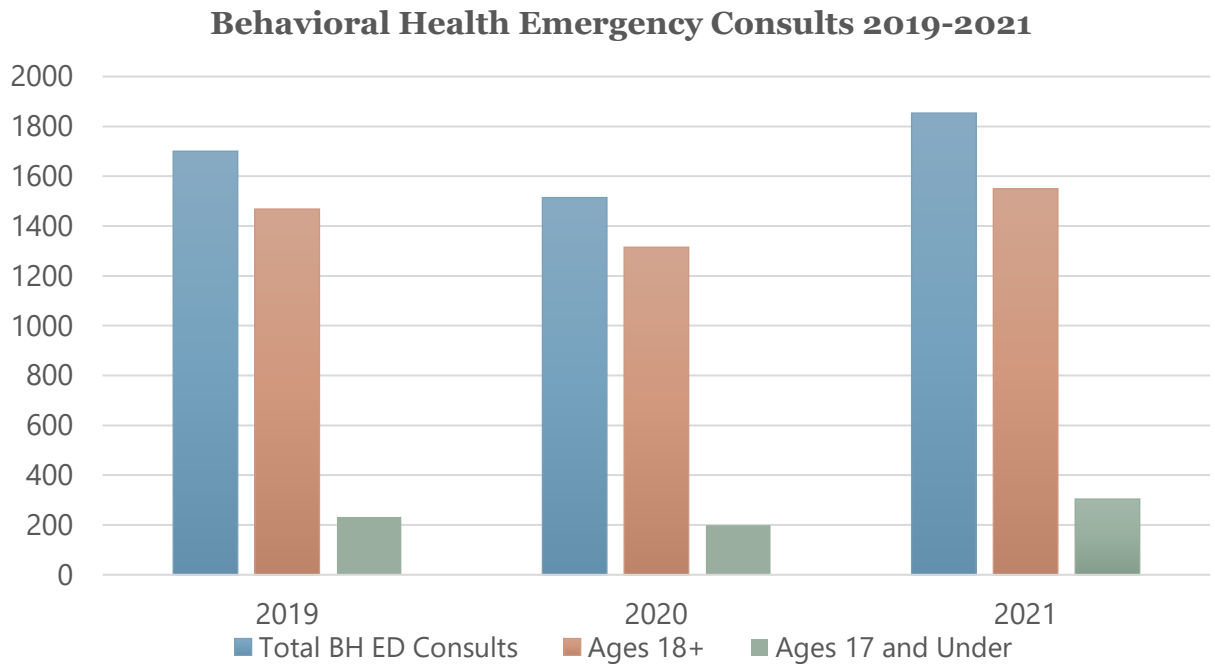
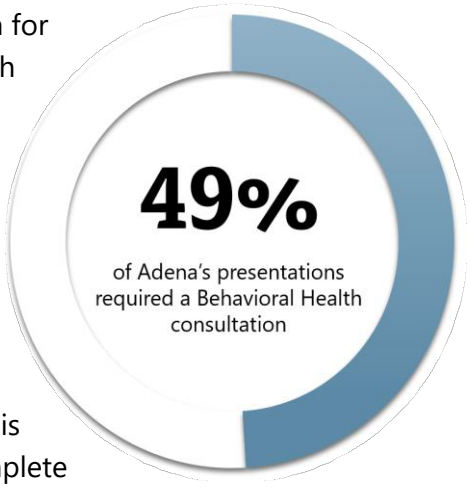


Figure 8

According to the Healthcare Cost and Utilization Project funded by the Agency for Healthcare Research and Quality, one in every eight emergency department visits in the United States is

related to a behavioral health issue.[16] The rate of growth for behavioral health consultations needed in Adena Health System's emergency department exceeds the national trend of rising behavioral health related emergency department visits; from 2006 to 2014, the national average rose to 44.1% and in 2021, 49% of Adena's presentations required a behavioral health consult.[17]



After presenting to the emergency department, Adena staff complete a psychiatric assessment, a departure from other county-based behavioral health systems where regional crisis providers like Scioto Paint Valley Mental Health Center complete assessments. The exception occurs if an individual is presenting to be assessed for admittance to the regional state hospital. After a clinical determination is made, individuals may be admitted to the psychiatric inpatient unit located on-site at Adena Regional Medical Center, referred to as 1A.

Figure 9 breaks down the reasons and percentages of individuals who required psychiatric inpatient care but were not admitted to 1A. Individuals are denied from 1A primarily due to either a substance use need exceeding the ability of 1A, lack of bed availability at 1A, patient request for transfer, and the presenting acuity is too high for the current milieu of 1A.

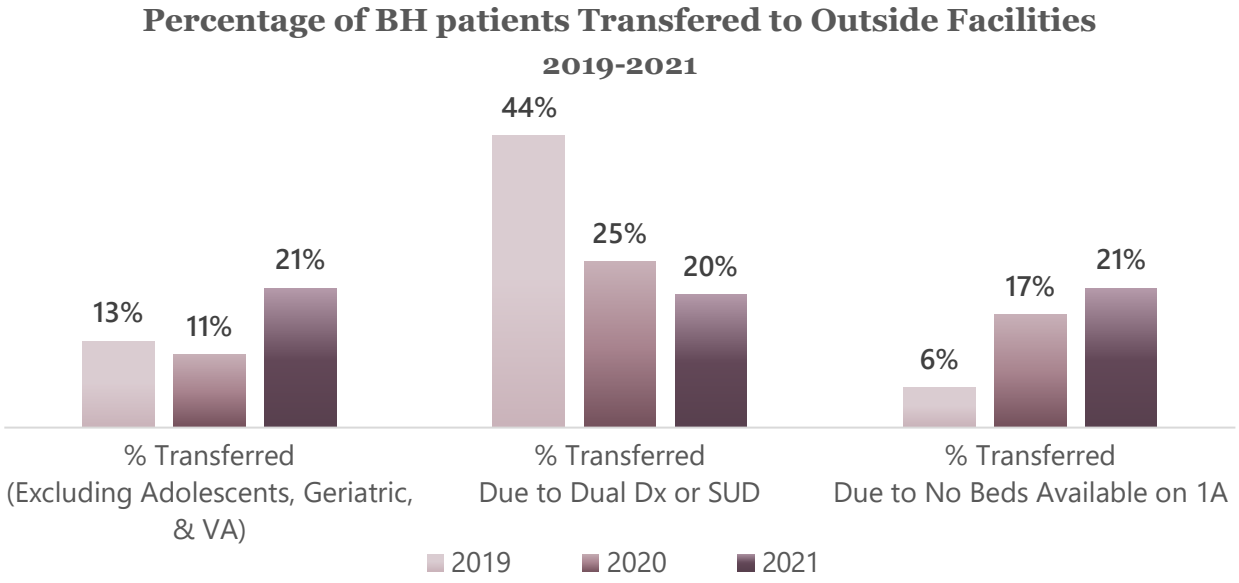


Figure 9

[16] Moore BJ (IBM Watson Health), Stocks C (AHRQ), Owens PL (AHRQ). Trends in Emergency Department Visits, 2006–2014. HCUP Statistical Brief #227. September 2017. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf

[17] Ibid.

Highland District Hospital

From October 1, 2020, through October 1, 2021, 192 individuals presented to the Highland District Hospital emergency department for suicide related needs, including suicidal ideation or a suicide attempt. Twenty-three percent of those presenting were 18 years old or younger. Highland District Hospital reviewed youth cases from the identified time period in an effort to better serve youth who present with behavioral needs in the emergency department, yet have difficulty being placed in an appropriate level of crisis care.

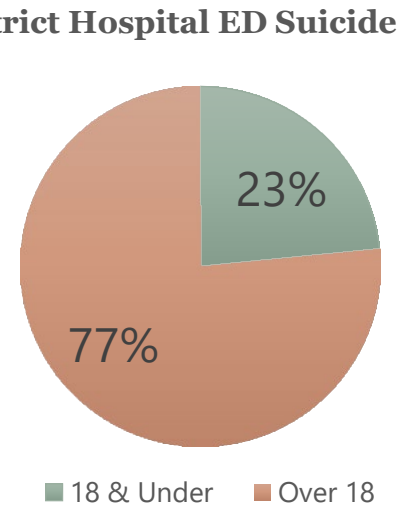


Figure 10

Highland County's total population includes 43,161 individuals, and 23 percent of individuals are 18 years old or younger.

Scioto Paint Valley Mental Health Center: Floyd Simantel Center

Scioto Paint Valley Mental Health Center operates Floyd Simantel Clinic in Ross County. According to the Center's brochure, the program "provide[s] 24-hour intensive programming consistent with the individual's needs in a safe, structured environment. These services may be utilized to prevent or shorten a psychiatric hospitalization, to assist individuals in returning home or back to their community following psychiatric hospitalization and/or to assist individuals in developing the skills required for independent community living."

Floyd Simantel Clinic is not a Crisis Stabilization Unit. Despite being operational 24-hours a day and 7-days a week, Floyd Simantel Clinic does not accept admissions outside of business hours. Psychiatric prescriber access is also limited, with two Nurse Practitioners covering the 18-bed facility for a total of four days per week. There are no Peer Support Specialists employed by SPVMHC, including at Floyd Simantel Clinic. Due to a profound lack of clarity specific to admission and discharge criteria, length of stay varies widely as compared to a Crisis Stabilization Center

which average three to 28 days, nationally.[18] Length of stay at Floyd Simantel Clinic varies by referral source.

In 2021, Floyd Simantel Clinic received 88 referrals, serving 57 unique individuals. Lengths of stay ranged from 1 to 194 days, with an average length of stay of 34 days. All referrals in 2021 that had a length of stay exceeding 100 days are included in Figure 11 below. Longer than average length of stays throughout the behavioral health crisis continuum should be reviewed and problem solved in future community-stakeholder meetings.

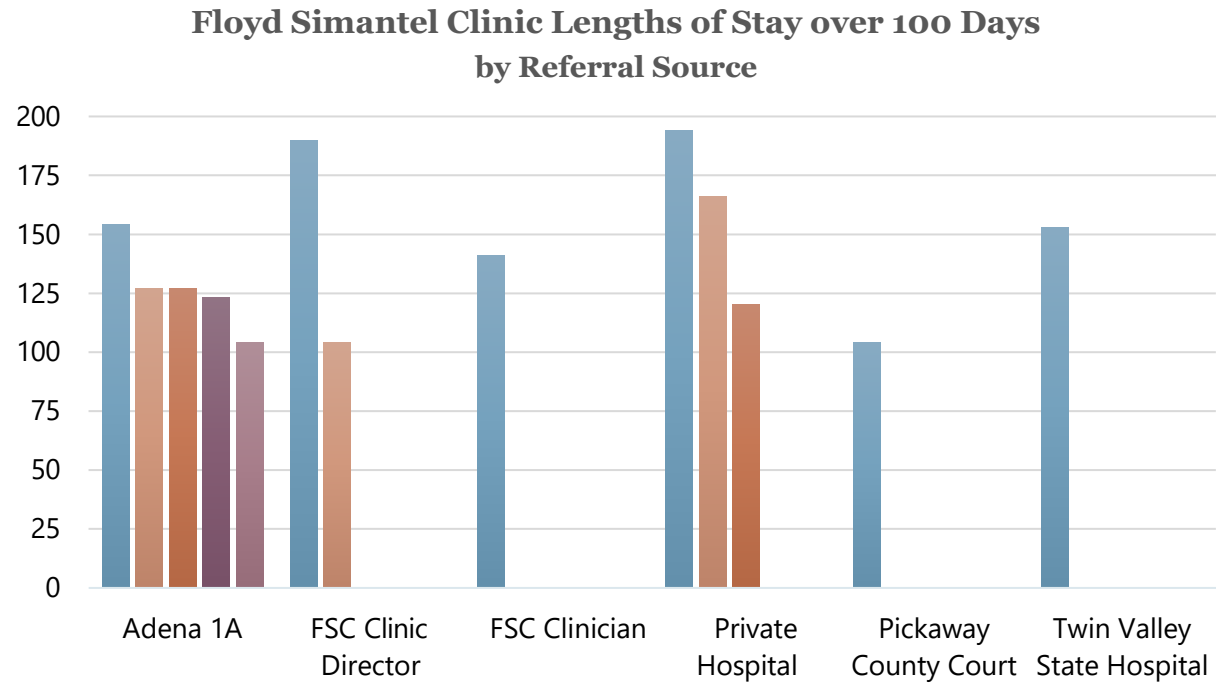


Figure 11

The majority of referrals to Floyd Simantel Clinic were made by Adena's psychiatric unit, 1A with 30 referrals. Top referral sources also included the county clinic discharge planners (12 referrals), and the Floyd Simantel Clinic Director (10 referrals), as displayed in Figure 12.

[18] TBD Solutions LLC. (2018). Crisis Residential Best Practices Handbook. (pp. 1-57). TBD Solutions LLC.

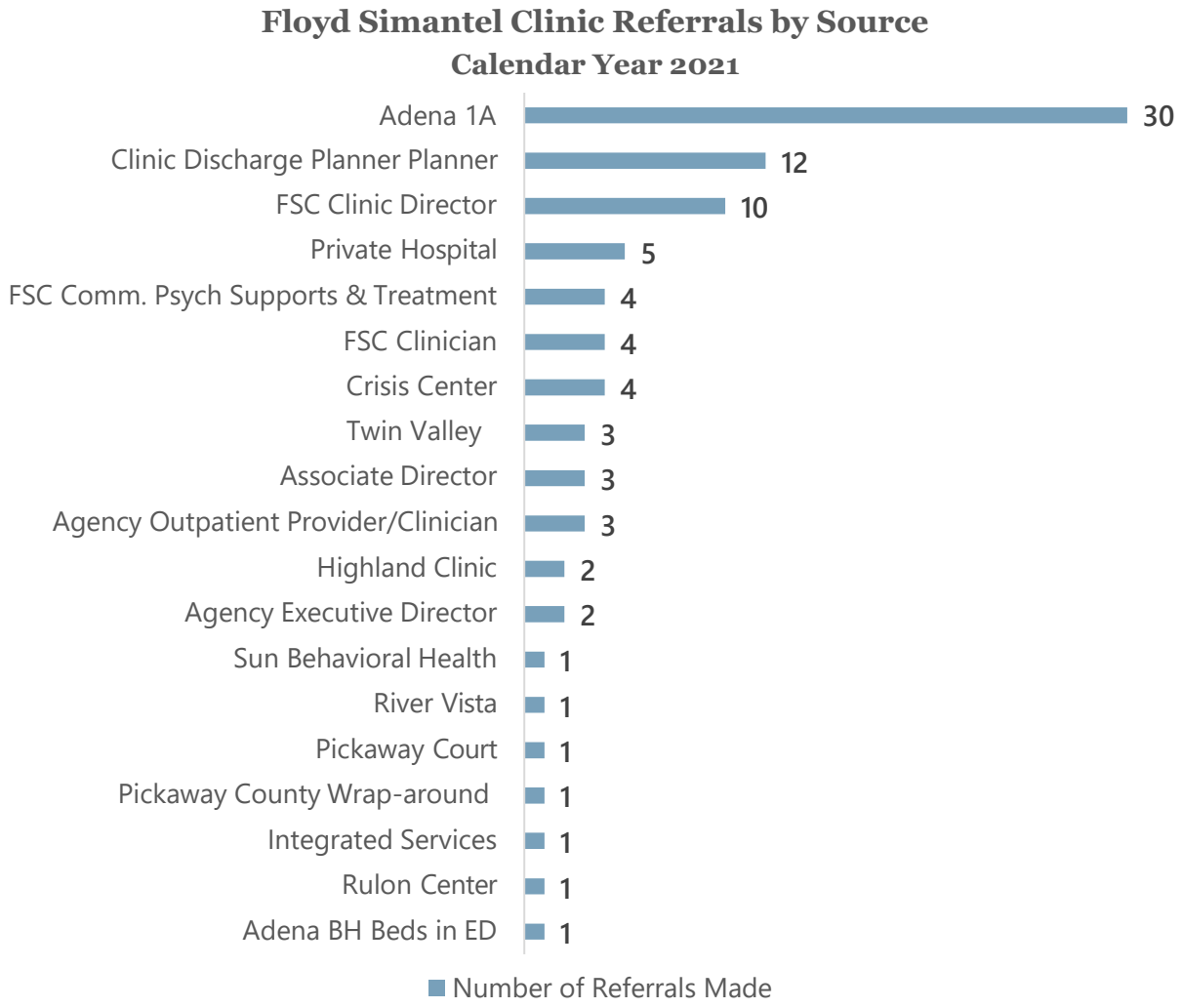


Figure 12

Scioto Paint Valley Mental Health Center: Crisis Call Center

Scioto Paint Valley Mental Health Center operates the crisis call center for the five-county catchment region. The Crisis Call Center operates 24 hours a day, seven days a week. The center accepts crisis calls as well as information and referral inquiries. As a certified National Suicide Prevention Lifeline (NSPL) center, Scioto Paint Valley Mental Health Center is required to track data specific to types of calls and demographic details of callers; however, this data was not shared with TBD Solutions as a component of its metrics request made. The Paint Valley ADAMH Board did provide the performance report from the NSPL for the month of January in 2022, represented in Table 1 below. Most calls originated in Ross and Fayette County, with Highland and Pike County contributing less than six NSPL calls combined for the month. **It is noted that an answer rate of 93% is extremely high, and above the national goal to average a 70% answer rate in the first year of 988 go-live.**

Table 1

Calls Offered	70
Calls Answered	65
Average Answer Rate	93%
Average Talk Time	11 minutes 13 seconds

In addition to the NSPL report, the Paint Valley ADAMH Board provided one month's worth of Crisis Call Center data from Scioto Paint Valley in November of 2021. In that month, 291 calls were received. On average, only 25 percent of calls received through the Crisis Call Center originate from the National Suicide Prevention Lifeline. *Additionally, 69 percent of calls during the identified time frame were abandoned, with only* ***90 calls answered in the month***. For crisis calls, especially calls routed through the NSPL, the result of an abandoned call from a high-risk caller is far more significant. Calls abandoned in the first ten seconds are often considered false calls, in which the wrong number was dialed.[19] Currently, there is no national benchmark for abandoned call rates.

Increased standards from the Paint Valley ADAMH Board specific to the life saving measures taken through Crisis Call Center services are integral to the continued improvement of service delivery. Neither NSPL, the American Association of Suicidology, nor the Alliance on Information and Referral System have a published standard for abandonment rate. However, industry standards for an acceptable abandonment rate are often less than ten percent.

[19] Bocklund, L. (2013). Is Benchmarking All There Is? Contact Center Pipeline. https://www.strategiccontact.com/articles/Contact-Center-Benchmarking-Oct2013.pdf.

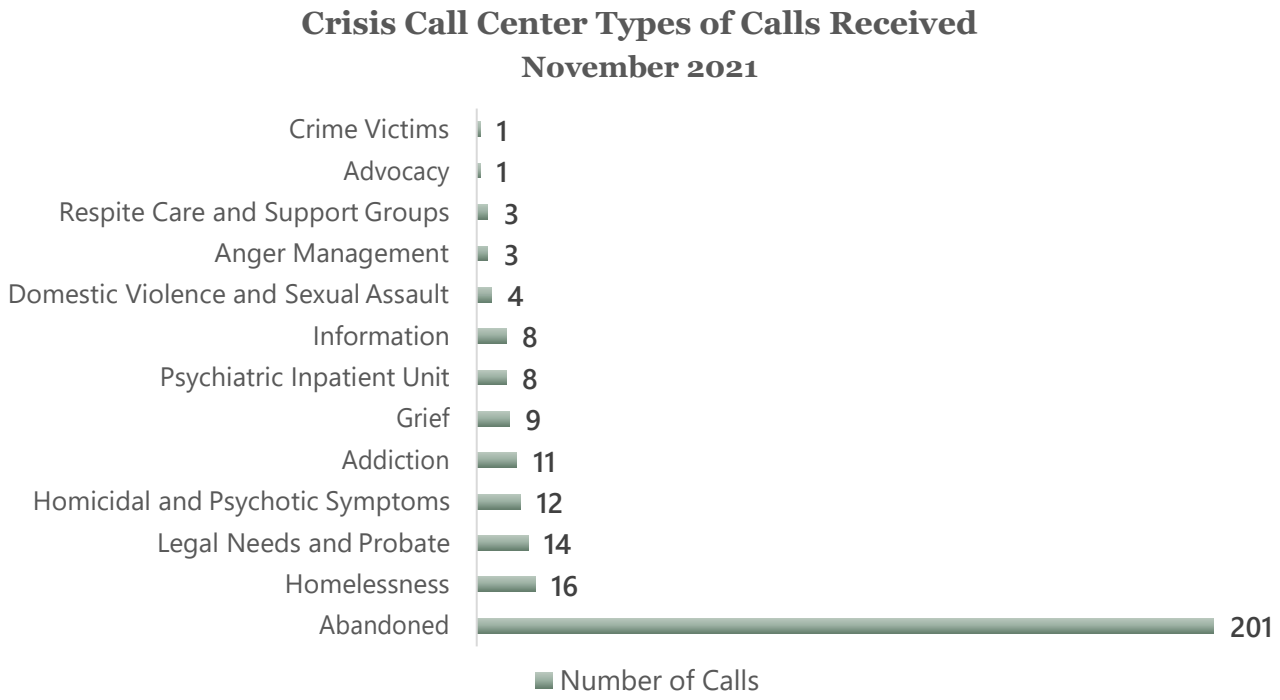


Figure 13

Satisfaction Data

Scioto Paint Valley Mental Health Center reports satisfaction survey results annually to the Paint Valley ADAMH Board. The survey contains seven questions that respondents are asked to rate on a 5-point Likert scale. Surveys are primarily distributed and returned via mail, although it was reported that each county crisis center periodically distributes a satisfaction survey to a person served.

In 2021, approximately 3,500 individuals were served by Scioto Paint Valley Mental Health Center.[20] Of those served, 51 client satisfaction surveys were returned (1.5%).

Detailed results from the satisfaction survey can be found in Appendix A.

[20] This number excludes those served through in-school prevention services and the crisis call center.

Population Health Analysis

A population health analysis was conducted utilizing fourteen county characteristics, ten counties spanning the United States were identified as the most like Fayette, Highland, Pickaway, Pike, and Ross Counties.[21, 22]

Disabled	Veteran
Medicaid recipient	Income below the poverty level
Uninsured	Not identified as active in labor force
White	Average household size
Black or African America	Rent as percent of income
Hispanic or Latino	Married family households
Foreign born	Single mother households

The ten similar counties were ranked with each Paint Valley County based on suicide rate, prolonged mental stress, drug overdose, and prescription opioid overdose.

Fayette County ranked closely with communities that have a higher-than-average rates of disabled and white population living below the poverty level.

Table 2. Fayette County

Characteristic	Fayette County	Ohio Average	US Average
Disabled	18%	14%	12%
White-Alone	94%	81%	72%
Below Poverty Level	16%	13%	14%

[21] U.S. Census Bureau. (2019). 2005-2019 American Community Survey 5-year Public Use American Community Survey 5-Year Data (2009-2020) (census.gov) retrieved from: Walker K, Herman M (2022). tidycensus: Load US Census Boundary and Attribute Data as 'tidyverse' and 'sf'-Ready Data Frames. R package version 1.2.1.9000, https://walker-data.com/tidycensus/.

[22] PLACES: Local Data for Better Health, County Data 2021 release: PLACES: Local Data for Better Health, County Data 2021 release | Chronic Disease and Health Promotion Data & Indicators (cdc.gov)

Highland County ranked closely with communities that have higher-than-average disabled, Medicaid recipients who are white and not in the labor force.

Table 3. Highland County

Characteristic	Highland County	Ohio Average	US Average
Disabled	18%	14%	12%
Medicaid	30%	20%	20%
White-Alone	96%	81%	72%
Not in Labor Force	35%	29%	29%

Pickaway County ranked more closely with communities that have average rates of county characteristics, however they did rank higher-than-average for those identifying as white, not engaged in the labor force, and married family households while having a lower-than-average rate of individuals receiving Medicaid benefits.

Table 4. Pickaway County

Characteristic	Pickaway County	Ohio Average	US Average
White-Alone	93%	81%	72%
Not in Labor Force	36%	29%	29%
Married Family Household	55%	46%	48%
Medicaid	17%	20%	20%

Pike County ranked closely with communities that have much higher-than-average rates of disabled, Medicaid recipients, who are not engaged in the labor force.

Table 5. Pike County

Characteristic	Pike County	Ohio Average	US Average
Disabled	24%	14%	12%
Medicaid	35%	20%	20%
White-Alone	96%	81%	72%
Not in Labor Force	39%	29%	29%

Ross County ranked closely with communities that have slightly higher-than-average rates of disabled, white, Medicaid recipients. Ross County had very similar results to Fayette County.

Table 6. Ross County

Characteristic	Ross County	Ohio Average	US Average
Disabled	19%	14%	12%
White-Alone	90%	81%	72%
Below Poverty Level	16%	13%	14%

A full breakdown of each county comparison based on suicide rate, prolonged mental stress, drug overdose, and prescription opioid overdose can be found in Appendix B.

Network Adequacy

Network adequacy in crisis services refers to the capacity of services needed to meet the demands of the community. Behavioral Health providers contracted with the Paint Valley ADAMH Board must be prepared to meet those needs through the development of a comprehensive crisis continuum. Pike, Fayette, Highland, Pickaway, and Ross counties have populations ranging in size from 27,000 to 77,000 individuals. With the total combined population of the Paint Valley region reaching 235,573,[23] the Crisis Resource Need Calculator (explained in the following section), calculates an average of 5,654 crisis episodes can be expected annually.[24]

In 2018, the Michigan Department of Health and Human Services (MDHHS) established regional network adequacy standards for crisis residential units. The standards state that every region with a population of 500,000 or more must have 16 adult CSU beds and 8-12 youth CSU beds.[25] Based on these requirements and current population data, the Paint Valley region needs approximately 8 adult CSU beds and 4 youth CSU beds.

Rural communities, like those in the Paint Valley region, make special considerations to tailor the range of crisis services offered to meet the unique needs of their community. Best practice

---

[23] See Footnote 1.

[24] Broadway, E.D., Covington, D.W. (2018). *A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness* (pp. 1-14). National Association of State Mental Health Program Directors. https://nasmhpd.org/sites/default/files/TACPaper5_ComprehensiveCrisisSystem_508C.pdf

[25] Behavioral Health and Developmental Disabilities Administration. (July 2020). MDHHS Network Adequacy Standards—Medicaid Specialty Behavioral Health Services. MDHHS BHDDA. https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder78/Folder2/Folder178/Folder1/Folder278/Procedure_MDHHS_Network_Adequacy_Standards_--_Medicaid_Speciality_Behavioral_Health_Servic.pdf?rev=e4f8cf5b1cab4d4099566655f2cbe33e

recommendations serve as a benchmark for building, enhancing, and sustaining local crisis networks. The publications *The Roadmap to the Ideal Crisis System*[26] and *National Guidelines for Behavioral Health Crisis Care-A Best Practice Toolkit*[27] inform the current gap analysis.

Pike County

Pike County has the smallest population of the five counties in the Paint Valley region, with a population of 27,089.[28]Adena Pike Medical Center and a county clinic of SPVMHC are in Pike County. The SPVMHC Pike County Clinic provides mental health and substance use disorder (SUD) care management and services coordination, mental health and SUD crisis intervention, intensive outpatient SUD treatment, outpatient mental health and SUD treatment, and SUD and addiction prevention. Many of the services provided by Pike County Clinic are available for adults and children.

Fayette County

Fayette County has a population of 28,906.[29] Adena Fayette Medical Center, SPVMHC Fayette County Clinic, and Pickaway Area Recovery Services (PARS)/Fayette Recovery Center (FRC) are present in the county. SPVMHC Fayette County Clinic offers mental health and substance use disorder (SUD) care management and services coordination, mental health and SUD crisis intervention, outpatient mental health and SUD treatment, and SUD and addiction prevention. Like Pike County, many services are available for adults and children. PARS provides SUD case management services and coordination, SUD crisis intervention, residential SUD treatment for women, intensive and outpatient SUD treatment, and SUD and addiction prevention.

Highland County

Highland County has a population of 43,354.[30] Highland District Hospital, two SPVMHC clinics, and Family Recovery Services (FRS) are present in the county. The SPVMHC Highland County Clinic offers mental health and substance use disorder (SUD) care management and services coordination, mental health and SUD crisis intervention, intensive outpatient SUD treatment, outpatient mental health and SUD treatment, and SUD and addiction prevention. The SPVMHC Lynn Goff Clinic, a women-only facility, provides SUD case management and services coordination, SUD crisis intervention, intensive outpatient SUD treatment, and outpatient SUD treatment. FRS is in Highland County and serves approximately 500 individuals' agency wide. FRS offers substance use and mental health counseling and medication assisted treatment (MAT). FRS operates Connections Day Treatment for children and adolescents, and The Randall L. Maissie House that provides a sober living environment and intensive substance use treatment.

---

[26] See Footnote 2.
[27] See Footnote 3.
[28] See Footnote 1.
[29] Ibid.
[30] Ibid.

Pickaway County

Pickaway County has a population of 59,333.[31] The county is home to OhioHealth Berger Hospital, SPVMHC Pickaway County Clinic, and PARS. The SPVMHC Pickaway County Clinic offers mental health and substance use disorder (SUD) care management and services coordination, mental health and SUD crisis intervention, intensive outpatient SUD treatment, outpatient mental health and SUD treatment. PARS offers SUD case management services and coordination, SUD crisis intervention, residential SUD treatment for men and women, intensive and outpatient SUD treatment, SUD and addiction prevention, and a driver intervention program.

Ross County

Ross County, the largest in Paint Valley, has a population of 76,891.[32] Due to its size, Ross County is home to the most crisis services. These include, Adena Regional Medical Center (psychiatric inpatient unit), Adena Greenfield Medical Center, and Adena Pediatrics. SPVMHC has three clinics in Ross County including, Floyd Simantel, Martha Cottrill Clinic, and the Rulon Center. The three clinics offer mental health and substance use disorder (SUD) care management and services coordination, mental health and SUD crisis intervention, intensive outpatient SUD treatment, outpatient mental health and SUD treatment, and SUD and addiction prevention. The Rulon Center is a men's only facility. Two other services present in the county are The Recovery Council and The Roweton School. The Recovery Council provides outpatient services to men, women, and adolescents. The Roweton School is operated by Integrated Services for Behavioral Health and provides a holistic educational approach for students experiencing challenging behavioral issues.

Crisis Resource Need Calculator

The gap analysis offers an estimate of crisis system resource allocation for the Paint Valley region using the Crisis Resource Need Calculator. The tool analyzes population size, average length of stay in various systems, escalation rates to higher levels of care, readmission rates, bed occupancy rates, and local costs to compute a customized estimate of crisis system needs. The Crisis Resource Need Calculator is one tool available to communities and should be used in conjunction with other research and analysis. [33]

To obtain an estimate of crisis system resource allocation for the five counties in the Paint Valley region, the following information was included in the calculations. In the Paint Valley region there are a total of 14 psychiatric inpatient beds. Adena Regional Medical Center in Ross County is home to the 14 psychiatric inpatient beds for individuals requiring close and continuous medical and clinical intervention. The average length of stay (ALOS) at Adena's psychiatric inpatient unit is three to five days, with an average cost per-day of $3,500. The following data was entered into the Crisis Resource Need Calculator:

- **Population census of Paint Valley Region:** 235,573

[31] Ibid

[32] See Footnote 1.

[33] See Footnote 3.

- **ALOS of acute inpatient at Adena Psychiatric Inpatient Unit:** 5-days
- **Average cost of acute bed/day at Adena Psychiatric Inpatient Unit:** $3,500

Given the total population of the Paint Valley region and Adena's psychiatric inpatient unit average length of stay and average cost per day, the tool estimates the following crisis system needs:

Figure 14

After completing a thorough assessment of the Paint Valley Region, **TBD Solutions recommends developing a six chair 23-hour crisis observation unit, a six-bed crisis stabilization unit, and five total adult and youth mobile crisis teams**. TBD Solutions' recommendation deviates from the estimates of the Crisis Resource Need Calculator to best address the regions insufficient services and resources. TBD Solutions completed an in-depth assessment of the regions service adequacy and evaluated the regions ability to meet the needs of its population.[19]

The Paint Valley region has insufficient services and resources as evidenced by:

- Minimal to no formal partnerships between the regions crisis providers and outpatient care providers
- Inconsistencies in level of care tools being utilized, and the level of care determinations being made
- Unnecessary channeling of individuals in crisis from Adena emergency department via EMS to Adena Medical Center in Ross County for assessment by an Adena Medical Center clinician
- Insufficient number of psychiatric beds in the region. Adena Regional Medical Center in Ross County is the only county with 14 adult inpatient beds. There are no youth inpatient beds

The formation of five mobile teams instead of two allows 24/7 community response and coverage for youth and adults in each county with an average response time of one hour. TBD Solutions recommends six 23-hour observation chairs to account for time and distance barriers that result

from the unit being in Ross County. TBD Solutions recommends the development of six crisis stabilization unit beds in Pickaway County as it is centrally located.

Gap Analysis

As Scioto Paint Valley MHC is the contracted crisis provider, they represent all existing crisis services identified in the gap analysis.

About Crisis Centers/Access Centers

A crisis center, also referred to as an access center in many states, is a key component of an ideal crisis continuum. According to *The Roadmap to the Ideal Crisis System*[34], "in an ideal system, there needs to be a secure physical location (crisis center) that provides a place for people in behavioral health crisis to go or be brought by law enforcement or other first responders that is an alternative to going to an ER or to jail". A crisis center is commonly referred to as a hub, coordinating all available crisis services in a community. The crisis center structure may resemble a medical facility or urgent care center but focuses exclusively on behavioral health crises. When designing a crisis center it is essential to consider the experiences of persons with lived experience to ensure agency, choice, and dignity are prioritized in care delivery.

An ideal crisis center in a larger community operates 24/7/365 with access for first responders and provides a wide range of services from triage to care coordination. In rural communities, the crisis center may not operate 24/7 due to low volume of need. To offset the hours the crisis center is not operational and to ensure individuals experiencing a crisis have access to services, coverage in rural communities is achieved through mobile crisis teams and/or on-call staff picking up crisis calls. In certain rural communities, individuals experiencing a crisis are directed to the local emergency department during third shift or other times the crisis center is not operational.

Identified Gaps

The Paint Valley region currently has one crisis center operated by SPVMHC, located in Ross County. Currently, the crisis center does not provide 24/7 access for first responders. SPVMHC operates outpatient clinics in Pike, Fayette, Highland, and Pickaway counties, providing emergency assessments Monday through Friday during business hours. If an individual experiences an after-hours crisis in these counties, they must present at the local emergency department for assessment and coordination of crisis services. Depending on the county, either the emergency department or a SPVMHC health officer will complete an assessment. The assessment completed by the health officer may be virtual or in-person depending on health officer proximity, time of day, and location.

Although Ross County has a crisis center, the remaining four counties are unequipped to best meet the needs of individuals in crisis during non-business hours and weekends. In communities where individuals in crisis are advised to seek care at the emergency department, a narrative is reinforced that hospitals and medical based settings are the appropriate entry point for behavioral

[34] See Footnote 2.

health concerns. Emergency departments are not equipped with the resources and/or training to provide essential care coordination services to individuals in crisis, and this can result in an individual being hospitalized even if not clinically or medically necessary.

Table 7. Crisis Center/Access Center

Crisis Center/Access Center		
Focus Area	**Current**	**Ideal**
Operate a crisis center/access center	•	•
The crisis center/access center operates 24/7/365	•	•
Operate outpatient clinics across the region offering emergency assessment services	•	•
Emergency assessments are completed Monday-Friday during business hours	•	
No after-hours services are available in the outpatient clinics	•	
A secure non-hospital physical location for individuals experiencing a behavioral health crisis to go or be brought to by law enforcement or first responders		•
The center operates 24/7/365, offering telephone access, walk-in services, and access for first responders		•
The center offers medical triage, screening, assessment, intervention, and care coordination for individuals experiencing a behavioral health crisis without emergent medical concerns		•
The crisis center has capacity for extended evaluation and/or observation		•
The crisis center has access to emergent psychiatric intervention and initiation of MAT for addiction treatment		•
The crisis center has access to peer support specialists who provide outreach and engagement		•
If identified as such, the center serves as the primary hub, responsible for the functioning and coordination of crisis services		•

About 23-Hour Observation/Diversion Units

Twenty-three-hour observation units provide services to children and adults during the acute phase of their crisis. Extended observation is a valuable element of the crisis continuum for three reasons. First, the unit provides safe space and adequate time for an effective crisis evaluation to be completed. Second, by providing space and time for an individual in crisis to stay the unit allows the multidisciplinary team to intervene and avoid unnecessary hospitalization or inappropriate discharge. Lastly, the unit allows individuals in crisis and those decompensating due

to acute symptoms of mental illness to a receive thorough evaluation and treatment.[35] In certain communities, 23-hour observation units are co-located with the crisis center. Co-locating crisis services creates a multi-service access point for persons served while creating efficiencies in shared staffing and care coordination.

If possible, 23-hour evaluation and extended observation units should be located outside a hospital setting to avoid unnecessary hospital admission. In rural or less populated areas, crisis providers may collaborate with their local hospital to build the observation unit near the emergency department and its resources. "Regardless of location, 23-hour observation beds should maximize privacy and dignity on par with medical emergency services and the whole team should be focused on being welcoming, person-centered, hopeful and trauma informed, especially in settings where there is a high volume of client flow".[36] Care coordination is an integral component of a 23-hour observation unit and services should be closely linked to other parts of the crisis continuum to allow for fluid coordination of care and access.

Identified Gaps

The Paint Valley region does not offer 23-Hour Observation services. Individuals experiencing a behavioral health crisis in Pike, Fayette, Highland, and Pickaway counites can receive an emergency assessment at SPVMHC outpatient clinics Monday through Friday during business hours. Outside of operating hours, individuals in these counties must present to the emergency department for assessment. During the acute phase of a crisis, an individual's presentation and symptoms may be exaggerated due to intoxication, lack of sleep, or other external factors. "If such a presentation occurs within a setting or system with no capacity for extended observation (e.g., medical ER, walk-in center at an outpatient clinic), it is not at all uncommon for such clients to be admitted to inpatient units for safety, only to wake up the next morning in a very different state".[37] A crisis continuum that is inclusive of 23-hour observation services allows individuals experiencing a behavioral health crisis access to right size care in a less restrictive setting than the emergency department.

In Ross County, persons served can receive an emergency assessment at the SPVMHC crisis center or in the emergency department. The absence of 23-Hour Crisis observation services in the Paint Valley region places an undue burden on individuals in crisis and on the existing services that absorb these individuals, particularly emergency departments. Emergency departments are responsible for receiving individuals who are intoxicated and/or in crisis, and because of Emergency Medical Treatment and Labor Act (EMTALA) laws, hospitals are disincentivized from sending individuals to any other treatment facility besides an inpatient psychiatric hospital.

Table 8. 23-Hour Observation

23-Hour Observation		
Focus Area	**Current**	**Ideal**

[35] See Footnote 2.

[36] See Footnote 2.

[37] Ibid.

Operate a 23-hour observation unit		•
The 23-hour observation unit operates 24/7/365		•
Services are provided for up to 23-hour hours		•
The center offers screening, assessment, evaluation, observation, and intervention services		•
The center has separate spaces for children and adults, and services are available for both voluntary and involuntary individuals		•
Observation services are available to individuals who are intoxicated, and staff are equipped to initiate withdrawal management and/or overdose reversal		•

About Crisis Call Centers

A crisis call center serves a vital role in the ideal crisis continuum. Crisis call centers assists individuals experiencing a behavioral health crisis through emotional support and referrals to appropriate community care. While variation can be expected across crisis call centers due to geographic location, population size, and staffing, it is best practice for centers to have the following components.[19]

- **Widely known in the community.** To be most effective, community members and stakeholders must have awareness and understanding of crisis call centers.
- **Easily accessible,** so individuals do not have to interface with multiple operators and/or automated questions.
- **Services are available 24/7/365** to best meet the needs of the community. If resources and capacity do not allow for 24/7 access, a system is in place to ensure seamless coordination of care.
- **Practice guidelines and core competencies** are trained on for all crisis call center staff. Staff have training and capacity in triage, engagement, intervention, and risk assessment.
- **Linguistically competent** in that services should be delivered in the two most spoken languages in the services area and have access to translation services.
- **911 call dispatch coordination.** Behavioral health oriented 911 calls (that meet specific criteria) are triaged to the crisis call center.

Identified Gaps

As of 2022, there are approximately 15 crisis call centers in the state of Ohio. SPVMHC operates 24/7/365 crisis lines in Pike, Fayette, Highland, Pickaway, and Ross counties. Currently, none of the crisis lines offer text, videoconferencing, or web-based chat services. The crisis lines report the ability to schedule follow-up appointments, but workers commonly provide the clinic's phone number and instruct the caller to call to schedule an appointment themselves. If the caller is a current SPVMHC client, crisis line staff can schedule a follow-up appointment for that client with their provider. As a certified NSPL center, SPVMHC is required to track data specific to types of calls and demographic details of callers, however this data was not shared following TBD Solutions' data request.

A gap exists in SPVMHC crisis lines and the desired state specific to triage capabilities. Crisis lines should be equipped to answer all calls, and triage calls to a crisis line staff who is knowledgeable and equipped to respond. professionals in the community. [38] Currently SPVMHC crisis lines do not have the capability to accept and triage calls from 911 and other helplines. The crisis lines are not capable of triaging and dispatching mobile crisis services, referring individuals to an urgent care, emergency department, or other facility-based care.

Table 9. Crisis Call Center

Crisis Call Center		
Focus Area	**Current**	**Ideal**
Operate a crisis call center	•	•
The crisis call center operates 24/7/365	•	•
Crisis call centers are each certified by the NSPL	•	•
The crisis call center is responsible for tracking data on the type of call, length of call, outcome of call, in addition to other metrics	•	•
The crisis call center accepts crisis calls and information and referral inquiries	•	•
The center meets National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at risk of suicide	•	•
The crisis call center offers phone, text, videoconferencing, web-based chat services, and can make follow-up appointments		•
The crisis call center accepts and triages all calls, including calls from 911 and other helplines		•
The crisis call center is capable of triaging and dispatching mobile crisis services, referring individuals to urgent care, emergency department, or other facility-based care		•
Services offered by the crisis call center are available in other languages and/or translation services exist		•
The crisis call center develops technology and competencies supportive of crisis triage within the communities' 911 dispatch function		•

About Mobile Crisis

An ideal behavioral health crisis system offers timely and effective services capable of addressing an individual's unique needs. Mobile crisis services are one element of an integrated crisis system and are designed to be initiated in the community. By providing community-based intervention, mobile crisis teams afford individuals the opportunity to receive behavioral health stabilization and assessment in their lived environment.

The ability of a mobile crisis team to be dispatched and provide services in multiple locations reduces the likelihood of an individual in crisis interfacing with law enforcement and/or seeking

[38] See Footnote 2.

care through the emergency department. Once a mobile crisis team has helped to stabilize the individual and conduct an assessment, the team coordinates follow-up care. A mobile crisis team will connect the individual to a service provider in the community, and when possible, complete a warm handoff to ensure a smooth transition of care. Warm hand-offs are critical to facilitate while scheduling aftercare appointments. Warm hand-offs involve care coordination dialogue between providers and introduce the person served to a new provider before the care transition takes place. They provide a venue for information transfer to the new service provider, afford the person served an opportunity to begin building a relationship with the new service provider, and prove to decrease no-shows.[39]

Care coordination is a cornerstone of successful mobile crisis services. Mobile crisis teams connect individuals to medical and/or behavioral health services, and when appropriate, facilitate warm hand-offs to ensure continuity of care. Staff on mobile crisis teams have knowledge of community resources and understand how to access different services in the crisis system of care. Mobile crisis services are most effective when meaningful collaboration and partnership is established with medical and behavioral health entities.

Identified Gaps

Mobile crisis services are not available in any of the Paint Valley ADAMH region's counties for adult or youth. Presently, individuals experiencing a behavioral health crisis in the region must present to the emergency department or to SPVMHC's crisis center in Ross County. The ability of mobile crisis services to respond rapidly and divert individuals from the emergency department and potential psychiatric hospitalization can produce considerable cost savings.

[39] National Action Alliance for Suicide Prevention. (2019). Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care. Washington, DC: Education Development Center, Inc.

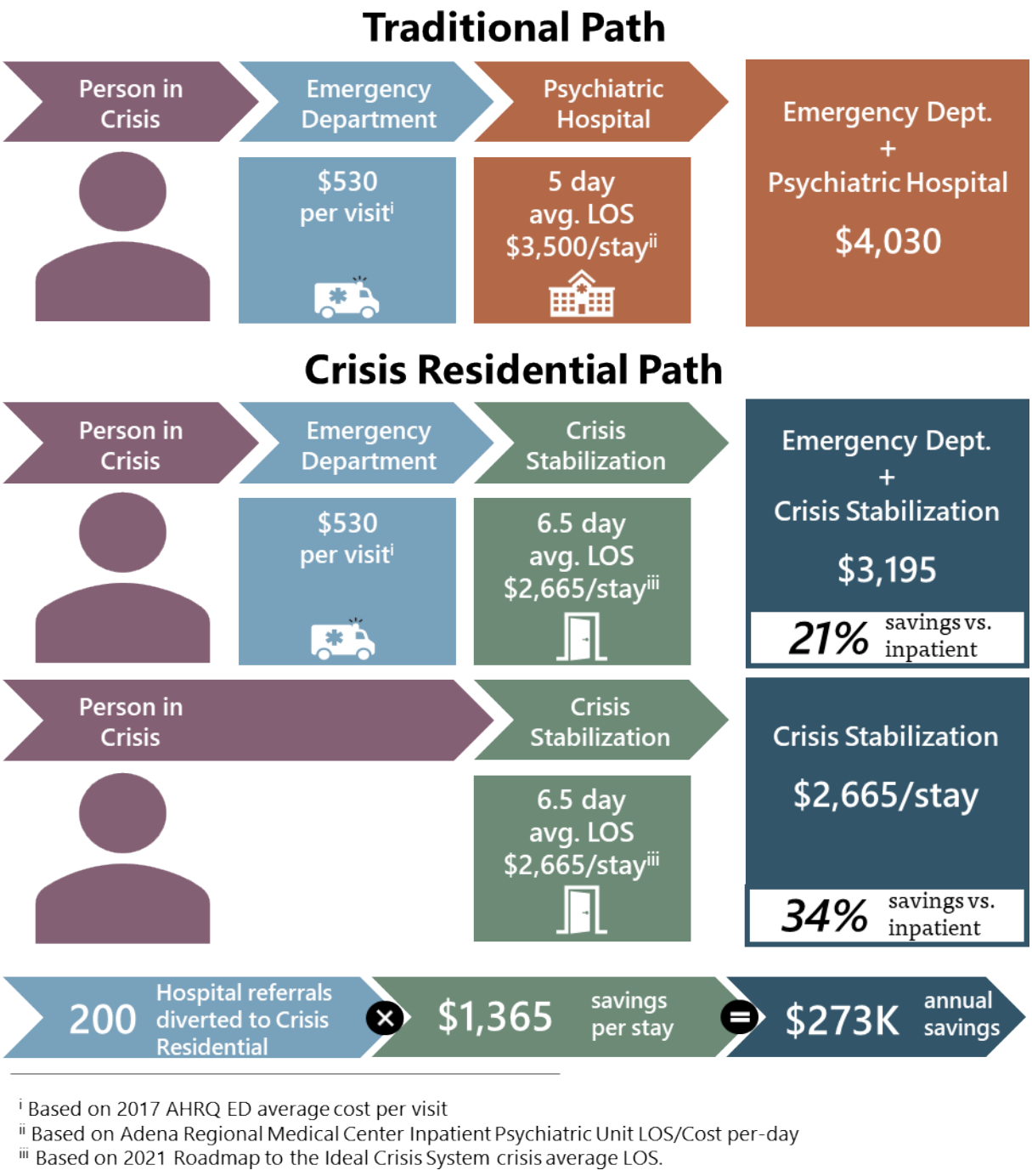


Figure 15. Crisis Residential Cost Savings

This infographic delineates a pathway of considerable cost savings—$273,000 annually—when using crisis stabilization units in partnership with other crisis services to divert individuals from both the Emergency Department and the psychiatric hospital.

Table 10. Mobile Crisis

Mobile Crisis		
Focus Area	**Current**	**Ideal**
Mobile crisis services are available in some capacity in the region		•
Mobile crisis services operate 24/7/365		•
Mobile crisis services offer assessment, crisis intervention, supportive counseling, collaboration with supports, information and referral, and care coordination services		•
Mobile crisis services will connect the individual to a service provider in the community, and when possible, complete a warm handoff to ensure a smooth transition of care		•
Staffing of mobile crisis services includes multidisciplinary team members, i.e., a combination of clinician plus peer support, nurse, case manager, or medic		•
Mobile crisis services respond to calls within one hour and are present in the community where the individual in crisis is located		•
Mobile crisis services respond to individuals in crisis without law enforcement whenever it is possible and safe to do so		•
Mobile crisis services utilize telehealth resources when in-person crisis response is not feasible, partnering with first responders to coordinate interventions		•

About CIT Trained Law Enforcement

Police and first responders responding to calls involving a behavioral health crisis should be trained in best practices in crisis intervention as well as aspects of the crisis continuum. "CIT is more than just a 40-hour training course. It is an organizational model designed to help prevent people from crisis and if in crisis, refer them to the mental health system instead of the criminal justice system when possible".[40] Communities should consider four components when implementing and sustaining the CIT model:

- **A CIT coordinator** is selected outside of the law enforcement department and is responsible for planning, coordinating, and implementing CIT
- **CIT liaisons** are selected from each department/station and meet quarterly with the CIT coordinator and behavioral health providers
- **Avoidance of law enforcement transport is prioritized.** Behavioral health professionals should be the first responder (when appropriate), and law enforcement should function as backup

[40] Futo, J., Long, J., Kasprzak, R. (March 2020). *Paint Valley CIT Peer Review.* Ohio Criminal Justice Coordinating Center of Excellence. https://www.neomed.edu/wp-content/uploads/CJCCOE_Paint-Valley-CIT-Peer-Review-2020.pdf

- **Jail diversion continuum** includes CIT functions as part of a larger community diversion program

Identified Gaps

The Paint Valley ADAMH Board began training law enforcement in CIT in May of 2013. As of February 2022, the region has trained approximately 172 officers. Chillicothe Police Department in Ross County is the only department with a trained social worker on staff who assists in police response.

- Fayette County: 4 officers
- Highland County: 36 officers
- Pickaway County: 32 officers
- Pike County: 15 officers
- Ross County: 85 officers

In March 2022, the Paint Valley region volunteered to be part of a comprehensive CIT Peer Review process.[41] At completion of the process, recommendations on improving CIT services were provided to the Paint Valley ADAMH Board. Recommendations centered on aligning CIT teaching blocks with best practice, implementing topic specific and advanced training opportunities, and involving emergency medical staff in trainings. The Paint Valley region continues to prioritize the CIT model and appears to be actively engaged in closing gaps that exist between their current state and best practice.

Table 11. CIT Trained Law Enforcement

CIT Trained Law Enforcement		
Focus Area	**Current**	**Ideal**
CIT Training is provided to all interested officers in the region	•	•
The accountable entity partners with first responders (such as law enforcement and EMS) to develop and implement a CIT training model	•	•
The CIT training model includes an overview of interacting with and respectful treatment of individuals with mental illness, and specialized training in behavioral health topics	•	•
The CIT coordinator plans, coordinates, and implements CIT classes and specialized trainings	•	•
The CIT coordinator and CIT liaisons meet regularly to debrief and staff cases as needed		•
When appropriate, behavioral health professionals serve as the first responder, and CIT officers serve as backup	•	•

[41] See Footnote 39.

About Crisis Stabilization Units

A crisis stabilization unit (CSU) offers a residential and home-like alternative to psychiatric hospitalization for individuals experiencing a behavioral health crisis. Also referred to as Crisis Residential Programs (CRPs), CSUs are designed for individuals who meet psychiatric inpatient admission criteria or are at risk of admission but can be treated in settings less intensive than a hospital. Additionally, crisis stabilization units serve as a step-down for people who have been receiving inpatient psychiatric care who are identified as no longer needing the inpatient level of care but would benefit from ongoing monitoring and supervision of the inpatient treatment plan before returning home.

A CSU offers 24-hour services, 365 days a year, in a structured facility-based setting that can accept people experiencing a crisis 24 hours per day, 7 days per week. The goal of the CSU is to reduce the intensity or severity their presenting problems that led to admission through a person-centered, recovery-focused, and resilience-oriented approach. Services are designed to resolve the immediate crisis and improve the overall functioning level of the individuals served and assist in a smooth transition back to the community. A comprehensive treatment team of clinicians, nurses, peer supports, and technicians provides psychoeducation and individual therapy.

Identified Gaps

SPVMHC operates Floyd Simantel Clinic in Ross County, an unlocked facility with 18 adult beds. Although Floyd Simantel has identifiable traits akin to a CSU, the center does not meet operational standards that consistently divert individuals from the emergency department or inpatient units. Columbus Springs, located in Franklin County, is the nearest CSU to Pike, Fayette, Highland, Pickaway, and Ross counties. Travel time from Columbus Springs to the five counties ranges from 1-2 hours by car.

Floyd Simantel reports that referrals can be made at any time, but referrals made outside of business hours (approximately 8am-5pm) are not reviewed until the following day. Managers of the program indicate it is not the norm to admit individuals experiencing a behavioral health crisis after hours because there is not leadership onsite to review the referral and its appropriateness. In 2021, the length of stay at Floyd Simantel varied tremendously, from 1 day to 194 days, with a median length of stay of 15 days. Floyd Simantel admits individuals to their program who are discharging on conditional release from the state hospitals. Leadership staff indicate forensic step-downs remain at the program for a minimum of 6 months to 2 years. There does not appear to be a streamlined or consistent process for discharge from Floyd Simantel.

Floyd Simantel employs a discharge planner to meet with an individual prior to discharge to connect them to aftercare, but there is notable variation in discharge planning. Discharge criteria at Floyd Simantel is poorly defined and appears to be subjective rather than rooted in assessment and clinical best practices on discharge and care coordination.

Table 12. Crisis Stabilization Unit

Crisis Stabilization Unit		
Focus Area	**Current**	**Ideal**
A CSU is available within the region for all counties to make referrals to		•
CSUs accept referrals and admissions 24/7/365		•
A CSU operates as an unlocked facility in a home or home-like setting		•
CSU beds are available in the region for both adults and youth		•
CSU functions as both a diversion and a stepdown from inpatient hospitalization		•
CSU staffing model includes peer support specialists or recovery coaches		•
CSUs employ clinical models that emphasize the recovery model, trauma-informed care, and evidenced-based practices such as CBT		•
CSUs offer therapeutic engagement through psychoeducational groups, group and individual therapy, and recreational activities		•
CSUs serve individuals with co-occurring mental health and substance use disorders and carry competencies of co-occurring treatment		•

About Partial Hospitalization Programs

Partial hospitalization programs (PHPs) play an integral role in the crisis continuum by providing therapeutic intervention and education in an unlocked setting. Individuals in PHP receive four or more hours of group and treatment per day. In addition to the wide range of therapeutic interventions that PHPs offer, specialty partial programs have emerged for sub-populations experiencing unique and specific stressors and symptoms such as:

- Children & adolescents
- Eating disorders
- Perinatal women

Identified Gaps

SPVMHC operates a partial hospital program for adults in Fayette, Highland, Pickaway, Pike, County. Programming takes place at each SPVMHC county clinic. In Ross County, PHP is offered at Floyd Simantel and advertised in their community brochure as a service designed to help individuals avoid psychiatric hospitalization. Currently, SPVMHC does not offer PHP for youth, or specialty PHP services.

Family Recovery Services, located in Highland County, operates The Connections Program, a day treatment program for children and adolescents. Day treatment provides group counseling and case management services to children beginning at eight years old who are on an IEP and experience a severe behavioral and emotional problem. The Connections Program offers targeted treatment for youth who cannot participate in traditional school settings. Youth are referred to day treatment by their local school district.

Integrated Behavioral Health Services operates the Roweton School which is available to Ross County students in grades six through 12. The school provides holistic educational services for students experiencing challenging behavioral issues.

Table 13. Partial Hospitalization Programs

Partial Hospitalization Programs		
Focus Area	**Current**	**Ideal**
Partial Hospital Programs are available in the region	•	•
Partial Hospital Programs prioritizes coordination of care and warm hand-offs with community behavioral health providers, physical health providers, and other support networks.	•	•
Partial Hospital Programs prioritize involvement and participation of family members, supports, and/or peer supports	•	•
Partial Hospital Programs are available to both youth and adults		•
Partial Hospital Programs accept all payer types	•	•
Group therapy is a key component of partial programming, the number and theme of groups offered varies based on population served		•
Partial Hospital Program staffing model includes peer support specialists or recovery coaches		•

About Psychiatric Inpatient Units

A primary goal of the ideal behavioral health crisis system is to divert individuals from psychiatric inpatient hospitalization by creating access to a continuum of community based, person centered services. Although diversion services are effective and less restrictive, inpatient units remain an important element in the crisis system, serving the most acute conditions while assuring safety and high-quality treatment.

Inpatient units are the most expensive and restrictive setting in the crisis continuum. To best meet the needs of individuals in crisis and ensure optimal care coordination, inpatient units must collaborate with all parts of the continuum and community members.

Furthermore, specialty psychiatric inpatient units have evolved to meet the needs of individuals in crisis who require expert care and intervention. Specialty units can include services for the geriatric population, persons with eating disorders, persons with a co-occurring serious mental illness and addiction, and persons with a co-occurring psychiatric illness and intellectual/ development disability or brain injury.

Identified Gaps

Adena Regional Medical Center in Ross County has a 14-bed inpatient psychiatric unit serving adults with a primary mental health diagnosis. Referred to as 1A, this unit provides comprehensive behavioral health treatment in a structured setting, assisting patients in stabilizing their symptoms

through groups, education, and medication management, currently 1A does not serve youth or operate any specialty programming or services.

Table 14. Psychiatric Inpatient Hospitals/Units

Psychiatric Inpatient Hospitals/Units		
Focus Area	**Current**	**Ideal**
Access to psychiatric hospital beds exist within the region	•	•
Inpatient units can accept voluntary patients and involuntary patients on emergency or short-term holds	•	•
Inpatient units accept individuals who have active substance use, medical conditions that can be managed at home if psychiatric care wasn't required, and individuals with intellectual/cognitive disabilities who are capable of basic self-care	•	•
Adequate staff-to-patient staffing ratios exist, and the multidisciplinary team includes nurses, techs, peers, clinicals, psychiatrics, and others	•	•
Inpatient units offer individual and group intervention services and treatment	•	•
Inpatient units can utilize seclusion, restraints, and forced medication, but strong emphasis is placed on reducing use of these interventions when at all possible	•	•
Inpatient psychiatric beds are available within a one-hour drive of each crisis access center		•
Inpatient psychiatric beds are available at a rate of at least 7 beds per 100,000 people		•
Clear standards and criteria are used to determine when inpatient hospitalization is medically necessary		•
Inpatient psychiatric beds are available in the region for both adults and youth		•

About Peer Respite

People experiencing a mental health crisis or psychiatric emergency need treatment options that align with their unique needs. While inpatient psychiatric hospitals have been the de facto treatment option for most communities, peer respites have emerged as viable alternatives for people who can thrive in an unlocked and less restrictive setting participating in psychosocial treatment with others who have lived experience.

A peer respite is a voluntary, short-term level of care that provides community-based and non-clinical support to people experiencing a self-identified mental health crisis. Services are delivered in a homelike environment by people with lived experience with mental illness or addiction, often called peer support specialists or recovery coaches. Peer respites are operated by three types of organizations: those that are entirely owned and operated by people with lived experience, those

that are partially owned and operated by people with lived experience, and those that employ people with lived experience, but their ownership does not identify as such.

Peer respites rely on the power of relationship and connection, often subscribing to the phrase "being with" people while minimizing hierarchal structures and encouraging agency and choice throughout their stay. Individuals are welcome to engage in the program at whatever frequency they feel comfortable with, and some guests may attend school or work during the day. Guests are responsible for managing their own medication regiment during their stay.

New York and California possess the most peer respite homes in the country, and Ohio, Georgia, New Hampshire, Wisconsin, and New Jersey each have more than one. Two of the newest peer respites in the country are the Wellness and Recovery Center in Toledo, OH (2018), and Promise Resource Network in Charlotte, NC (2021).

Identified Gaps

Although no peer respite programs exist in the Paint Valley Region, peer support services exist in some organizations. Ross County Community Action Commission offers peer support services for individuals seeking recovery from substance use and/or mental health problems. The National Alliance for Mental Illness (NAMI) of Southern Ohio serves the five-county region. NAMI of Southern Ohio provides education, advocacy, and support to individuals with mental illness and their families. NAMI hosts support groups in the five-county region, providing individuals a safe space to learn new coping skills and receive support.

The role of peer support specialists and recovery coaches in peer respite, peer drop-in centers, and the community can be best understood in three stages:[42]

1. **Before the crisis** staff provide community outreach, education, and engage in efforts to mitigate a crisis from occurring
2. **At the time of crisis** staff are integrated into behavioral health services and advocate and support persons served as they receive care
3. **As the crisis resolves** staff providing ongoing care coordination, and operate clubhouse models or drop-in centers that individuals can utilize

Peer support specialists are integral in a communities' crisis system and should be engaged in all levels of care. Peers can professionally and effectively build rapport and connect with others experiencing a crisis in a way that is not typically encouraged by other disciplines. **It is imperative that individuals and families with lived experiences are involved in all aspects of crisis system design and enhancement.** It is not sufficient for peers and families to simply invite them to the table; their voice must be heard and must inform system design.

[42] See Footnote 2.

Peer support specialists can be further integrated into the Paint Valley region in the following ways:

- Embed peer supports and recovery coaches in the Emergency Departments to provide first-contact support to individuals in a behavioral health crisis.
- Include peer services in aftercare for individuals discharged from acute services.
- Include peer supports in every crisis level of care, including within the leadership structure.

Table 15. Peer Respite

Peer Respite		
Focus Area	**Current**	**Ideal**
A peer respite is available in the region		•
Peer respite is owned and operated by persons with lived experience.		•
Peer respite has overnight staff and individuals can stay for multiple days		•
Peer respites operate with a unit cost under $300 per day		•
Peer respite programs are staffed by peer specialists and SUD recovery peer specialists (recovery coaches), with medical, nursing, or clinical services only being accessed as needed		•

Recommendations

1. Expand Crisis Services and Capacity

To assure timely access to high-quality services, TBD Solutions recommends the addition of the following crisis services:

A. Build a 23-Hour Observation Unit to provide walk-in crisis support.

Build a six chair 23-Hour Observation Unit in Ross County to divert individuals from Emergency Departments and avoid unnecessary hospitalizations. The 23-Hour Observation Unit should be secured and serve individuals in 23 hours or less. Ross County is the suggested location due to the density of the population within the county as compared to the other four counties within the region. Ross County is also the most centrally located amongst the region.

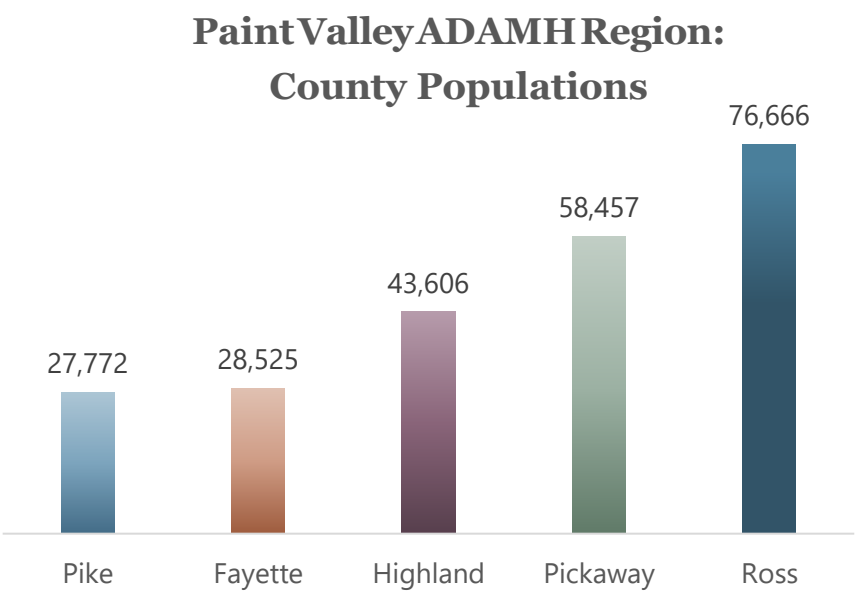


Figure. 16

A daily rate of $800 is recommended, with a minimum average utilization of 8 people per day, 365 days per year. The recommendation of a six-chair program assumes that two-thirds of patients will leave within 12 hours, allowing the provider to turn most chairs over daily. The services would be available to the full region, rather than individual counties.

The availability of additional staff may allow for medical clearance within a Crisis Stabilization Unit, but previous instances of medical issues ascertained from the medical clearance process of people presenting to emergency services in a behavioral health crisis. The MI-SMART[43] form is an evidence-based tool for standardizing the medical clearance process with behavioral health persons served in mind.

B. Build a Crisis Stabilization Unit to offer a less restrictive treatment option for those in an acute behavioral health crisis.

Build a six bed adult Crisis Stabilization Unit (CSU) in Pickaway County. Assure that the service operator demonstrates competencies and passion for the Crisis Stabilization Unit model and the referring doctors and clinicians are well-versed in the ability of the program to accept most people who meet psychiatric inpatient criteria.

Pickaway County is recommended as the site for the Crisis Stabilization Unit due to centrality and the current spectrum of crisis services available. While Ross County is the most centrally located

[43] Michigan Department of Health and Human Services, Michigan Health & Hospital Association. (January 2021). *MI-SMART Form.* MDHHS. https://www.mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/

throughout the region, Floyd Simantel Center is located in Ross County. Floyd Simantel Center does not operate within the standards of a Crisis Stabilization Unit and is not diverting nor stepping down psychiatric inpatient patients in the manner of a Crisis Stabilization Unit. As the Crisis Stabilization Unit consistently hits an 85% census rate, it is recommended that Floyd Simantel no longer serve as a short-term residential option to avoid confusion as well as ensure best practice care. If a waitlist is consistently required at the Crisis Stabilization Unit, repurposing beds to be licensed as CSU beds at Floyd Simantel should be considered.

Leadership from Scioto Paint Valley Mental Health Center explained that Floyd Simantel Center is "not typically for those in crisis mode." It was clarified that Floyd Simantel Center stepdown only take place from 1A and offer a residential option while individuals engage in partial hospitalization groups or intensive outpatient groups on-site. With that being said, the development of a Crisis Stabilization Unit should not compete with the services offered at Floyd Simantel Center.

Figure 17 demonstrates the **potential monthly throughput** of the Paint Valley Region's crisis services with the addition of both a 23-Hour Observation Unit and a Crisis Stabilization Unit. In 2021,1,853 individuals presented to an Adena Regional Medical Center in need of a behavioral health consult. In the same year 21% of individuals presenting in need of a higher level of care were transferred out of county for care. In this model, less than one-third of individuals presenting in a behavioral health crisis and prospectively meeting criteria for psychiatric inpatient hospitalization require a referral to the hospital.

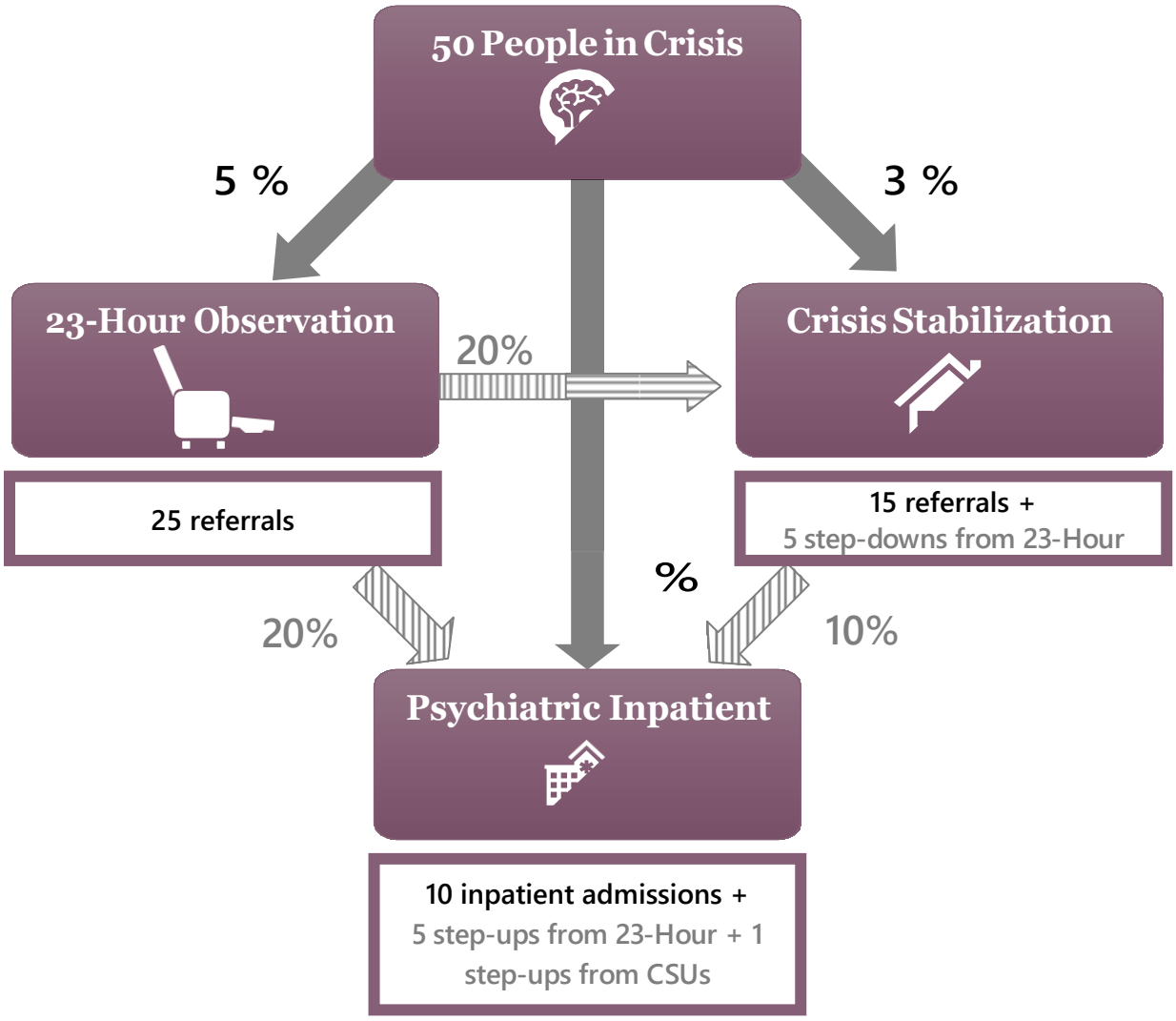


Figure. 17

C. Develop Mobile Crisis Teams to provide coverage over the entire 5-county region

Mobile crisis services are one integral element of an integrated crisis system and are designed to be initiated in the community. By providing community-based intervention, mobile crisis teams afford individuals the opportunity to receive behavioral health stabilization and assessment in their lived environment. The ability of a mobile crisis team to be dispatched and provide services in multiple locations reduces the likelihood of an individual in crisis interfacing with law enforcement and/or seeking care through the emergency department. Once a mobile crisis team has completed stabilization and assessment services, the team coordinates follow-up care to ensure the individual in need is connected to appropriate services moving forward.

The publication 'National Guidelines for Behavioral Health Crisis Care-A Best Practice Tool Kit'[44] reports the essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality
- Assessment
- De-escalation/resolution
- Peer support
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

TBD Solutions recommends the development mobile crisis teams to respond to both youth and adults experiencing a behavioral health crisis, in the community rather than the emergency department, following the models below.

Pike, Pickaway, & Ross County		
Combined Population **162,895**	**3 Teams** • 3 Masters Level Clinicians • 3 Peer Support Specialists	**24/7 Community Response** • Response Triaged • 1 Hour Response Average

Figure 18. Mobile Crisis Recommendations-Fayette, Pickaway, & Ross

Highland & Fayette County		
Combined Population **72,131**	**2 Teams** • 2 Masters Level Clinicians • 2 Peer Support Specialists	**24/7 Community Response** • Response Triaged • 1 Hour Response Average

Figure 19. Mobile Crisis Recommendations- Highland & Pike

2. Improve Care Coordination throughout the behavioral health crisis continuum in the Paint Valley Region

Care coordination is a cornerstone of effective crisis care, along with assessment, engagement, and treatment. In behavioral healthcare, care coordination is defined as a proactive approach to bringing providers together to meet the needs of persons served to ensure they receive integrated

[44] See Footnote 3.

and client-centered care across various treatment settings.[45] Care coordination is characterized by deliberate communication of clinical information to create efficient, safe, and uninterrupted care transitions from one service to another. Effective care coordination fosters the experience of discrete behavioral healthcare events for the person served as fluid and in a logical progression over time and consistent with their needs and preferences.[46]

The *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* states that crisis services should not be viewed as stand-alone resources, but rather an integrated part of a coordinated continuum of care.[47] Transition periods such as a discharge from a crisis care facility represent a time of increased risk for suicide.[48] Effective care coordination impacts increased safety and sustainability of treatment.

Within the Paint Valley Region assessment for the treatment of a behavioral health crisis occurs in several settings, by several providers, utilizing varying assessments to determine the appropriate level of care referral. As demonstrated through asset mapping, there are numerous entry points into the crisis continuum, with variance based on county. Such variance causes confusion and room for error within the system, ultimately leading to risk for persons served. An individual can present at one of the county crisis centers operated by Scioto Paint Valley Mental Health Center, or any emergency department except Adena to be assessed for a behavioral health crisis by Scioto Paint Valley Mental Health Center. There is variance, sometimes daily, on whether that assessment is completed over the phone, virtually, or in person. If an individual presents to an Adena emergency department they are transferred, via EMS, to Adena Medical Center in Ross County for assessment by an Adena Medical Center clinician. The administrative and transportation burden placed throughout the system due to the lack of consistency is exponentially costly.

TBD Solutions recommends streamlined processes for assessment, admission criteria, and discharge processes in an effort to improve care coordination. This starts with clarity specific to communication and collaboration. Communication and collaboration allow the time and space for service providers to consult and discuss historical and ongoing treatment decisions for the person served. Collateral sources, such as the individual's natural supports, may also be called upon to provide information, especially if the person is not willing or able to participate in the

---

[45] Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centered health services. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO

[46] Continuity and coordination of care, World Health Organization, 2018

[47] See Footnote 3.

[48] Chung, D. T., Hadzi-Pavlovic, D., Wang, M., Swaraj, S., Olfson, M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalization. BMJ Open, 9(3), e023883. Retrieved from http://dx.doi.org/10.1136/ bmjopen-2018-023883

assessment. Throughout the Paint Valley region's behavioral health crisis continuum, communication and collaboration check points should include the following:

Table 16

When	Who	How	Why
Prior to admission	Referral Source ⇄ Crisis Provider	Phone Call	Detail reason for referral and goal of treatment
	Referral Source ⇄ Crisis Provider	Electronic Records	Provide records outlining: • Reason for Referral • Assessment • Diagnosis • Medication List • Treatment History
	In the event of a step-down, Inpatient Psychiatric Unit Nurse ⇄ Crisis Provider	Phone Call	Detail treatment summary and relevant health conditions
During stay (*within 24-48 hours of admission*)[49]	Crisis Provider ⇄ Outpatient Provider	Phone Call	Consult on medication treatment plan
	Outpatient Clinician ⇄ Crisis Provider	Phone Call	Relay outpatient treatment plan and discharge plan
Prior to discharge	Crisis Provider ⇄ Outpatient Clinician	Phone Call	Arrange Aftercare
	Crisis Provider ⇄ Outpatient Provider(s)	Electronic Records	Provide records outlining: • Treatment Plan • Treatment Summary • Medication List • Safety Plan
	Crisis Provider ⇄ Referral Source	Electronic Records	Provide records outlining: • Treatment Plan • Treatment Summary • Medication List • Safety Plan

[49] There is no documented best practice surrounding the time frame in which an inpatient and outpatient provider should consult regarding medication treatment decisions, however, practice-based evidence suggests that collaborating within 24-48 hours of admission is ideal. This time frame supports the importance of the outpatient providers' historical knowledge of the persons served, while balancing the necessity of the crisis provider to make quick decisions in service of achieving stabilization.

For the greatest continuity of care, clear care coordination expectations should be documented in organizational policies. Organizational policies provide guidance to staff for effective and safe care transitions and specify the contacts and supports needed throughout the process. Policies should be reviewed and updated at least annually. An organizational policy detailing the coordination of care process for each of the following should exist within all crisis providers:

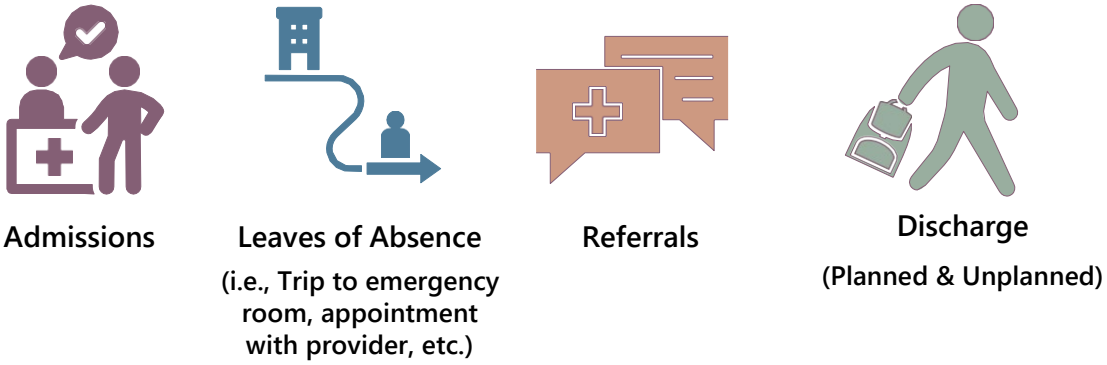


Figure 20.

3. Develop Outcomes Driven Care

The Paint Valley Region is lacking a comprehensive and collaborative data culture from which providers, the Paint Valley ADAMH Board, and community partners can reference key performance indicators to understand if the crisis system is functioning at its optimal level and people are accessing care quickly and care is delivered effectively.

Performance measures appear to play an extremely limited role in the current behavioral health crisis continuum throughout the region.

Savings actualized through the utilization of alternatives to high-cost services must be reinvested to assure sustainability of these crisis services. As the old social services adage goes, "No money, no mission." If services such as Floyd Simantel Center or the Crisis Call Center can demonstrate significant cost savings to the public behavioral health system, then that savings should go to ensure the continued sustainability of those programs, as well as other pilot projects.

Many county behavioral health authorities engage a re-procurement process every 7-10 years regardless of the performance of the providers. During this period, considerable changes may occur in behavioral health care delivery and organizational structure and personnel. Crisis service provider contracts should be determined based on previously determined performance measures and a commitment to and execution of best practices.

There is currently a profound lack of data shared throughout the Paint Valley region. TBD Solutions recommends:

- Every individual served in a short-term crisis setting is provided a **real-time opportunity to complete a satisfaction survey**. Each satisfaction survey is tracked and reported to the Paint Valley ADAMH Board **monthly**.

- Utilization data is **tracked monthly** by all behavioral health providers, inclusive of recidivism data.
- A bi-monthly stakeholder meeting is convened to **review the data** as a community and develop regional **benchmarks.**

Conclusion

A community's ability to develop and maintain a high-functioning behavioral health crisis system is predicated on two major factors: collaborative, humble relationships between the behavioral health providers and a shared vision for excellence. The quality of these working relationships can save years in the planning process.

Providers and payers must work together to define an effective system while assuring that risk is managed in a way that still serves the client's best interests. This includes alternative funding models besides fee-for-service.

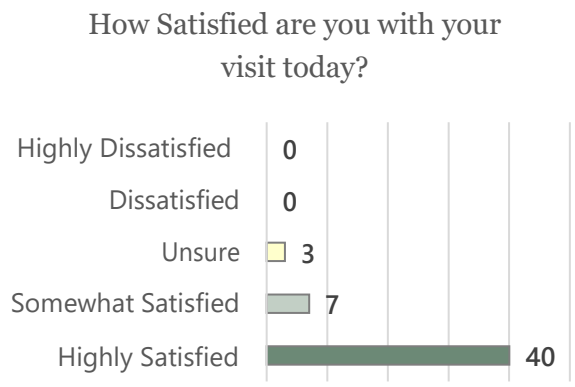
Lastly, additions to the crisis system will push existing providers to reimagine their identity in the crisis continuum. Just as medical urgent care centers challenged the status quo of Emergency Department treatment for nonemergent treatment decades ago, CSUs and Psychiatric Urgent Care Centers may require Emergency Departments and psychiatric hospitals to embrace a new vision for their place in the community's system of behavioral health care.

Appendix A: SPVMHC Satisfaction Survey Results

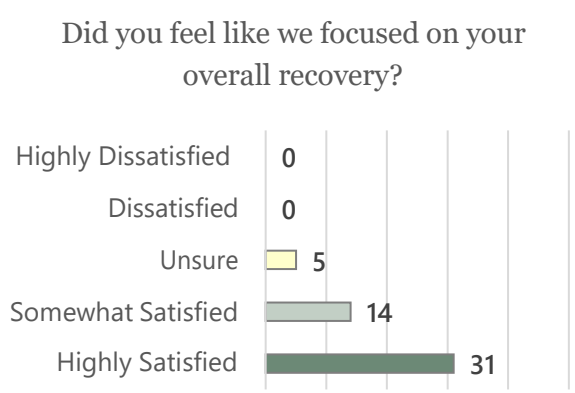
The Satisfaction Survey distributed by Scioto Paint Valley Mental Health Center asks recipients to respond to seven questions specific to satisfaction of care received. Questions are rated on a five-point Likert scale in which five indicated someone is highly satisfied, four indicated somewhat satisfied, three indicated the respondent is unsure, two indicated someone dissatisfied, and one indicated highly dissatisfied.

Results from 50 persons served through Scioto Paint Valley Mental Health Center are displayed below.

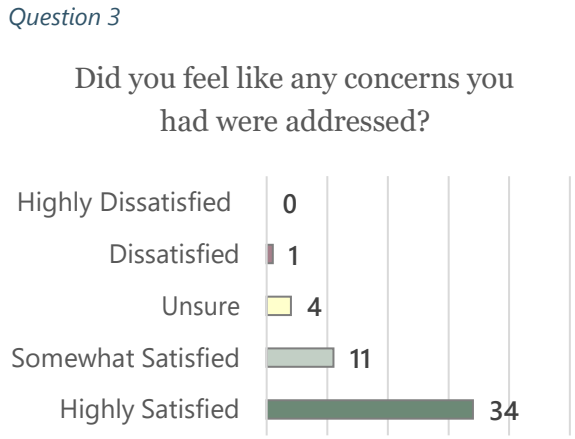
Question 1



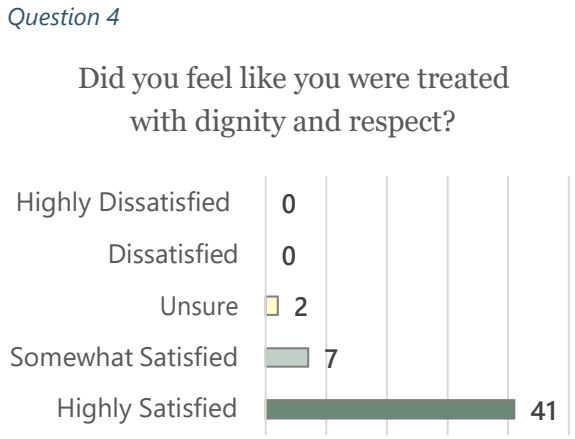
Question 2



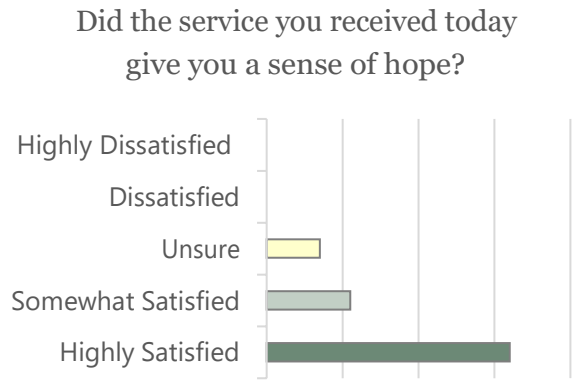
Question 3



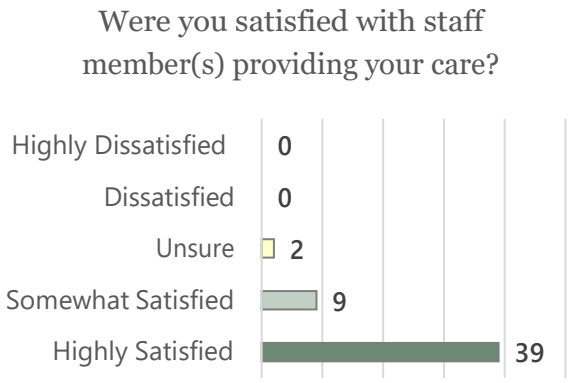
Question 4



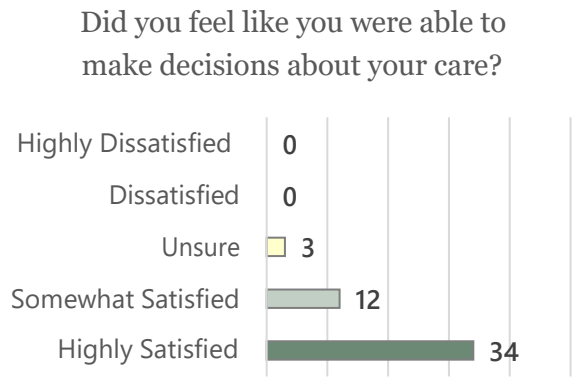
Question 5



Question 6



Question 7



*One person did not submit an answer to Question 7.

Appendix B: Population Health Analysis Graphs

Utilizing fourteen county characteristics, ten counties spanning the United States were identified as the most like Fayette, Highland, Pickaway, Pike, and Ross Counties. The fourteen county characteristics are demonstrated below. Each characteristic is aligned with the county rate compared to Ohio and national averages.

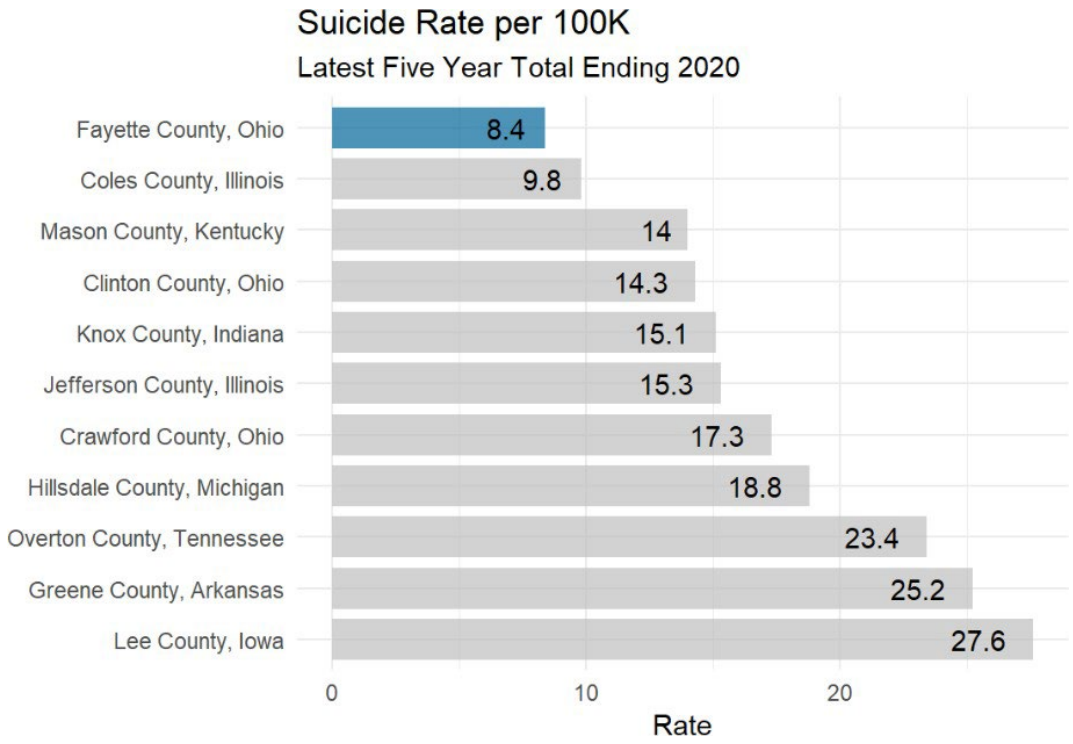
Characteristic	Ross	Pike	Pickaway	Highland	Fayette	Ohio	USA
Disabled	19%	24%	14%	18%	18%	14%	12%
Medicaid	24%	35%	17%	30%	25%	20%	20%
Uninsured	5%	7%	5%	8%	7%	6%	9%
White alone	90%	96%	93%	96%	94%	81%	72%
Black or African American alone	5%	2%	4%	1%	2%	12%	13%
Hispanic or Latino	1%	0%	1%	1%	2%	4%	18%
Foreign born	1%	0%	1%	1%	2%	5%	14%
Below poverty level	16%	18%	11%	19%	16%	14%	13%
Veteran	8%	8%	7%	8%	6%	6%	6%
Not in labor force	38%	39%	36%	35%	32%	29%	29%
Average household size	2.47	2.51	2.7	2.53	2.4	2.43	2.6
Rent as a percent of income	29%	29%	27%	28%	27%	28%	30%
Married family households	50%	50%	55%	49%	47%	46%	48%
Single mom households	6%	4%	5%	4%	6%	6%	5%

The ten similar counties were ranked with each Paint Valley County based on suicide rate, prolonged mental stress, drug overdose, and prescription opioid overdose.

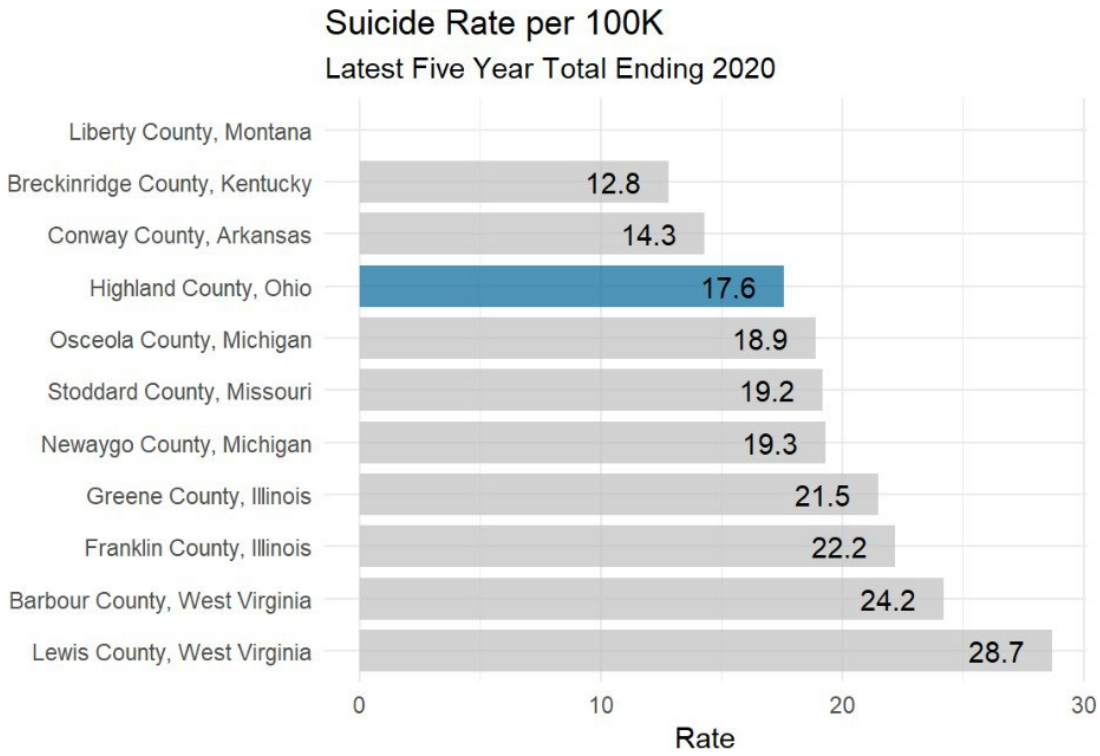
Suicide Rate The CDC collects data for each county within the United States specific to reported suicide rates per 100,000 people. Rates are averaged from years 2015-2020. The CDC will not provide data for counties whose total suicide count is less than 10. The national average for suicide rates per 100,000 people in 2019 was 13.9.[50]

[50] Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report.

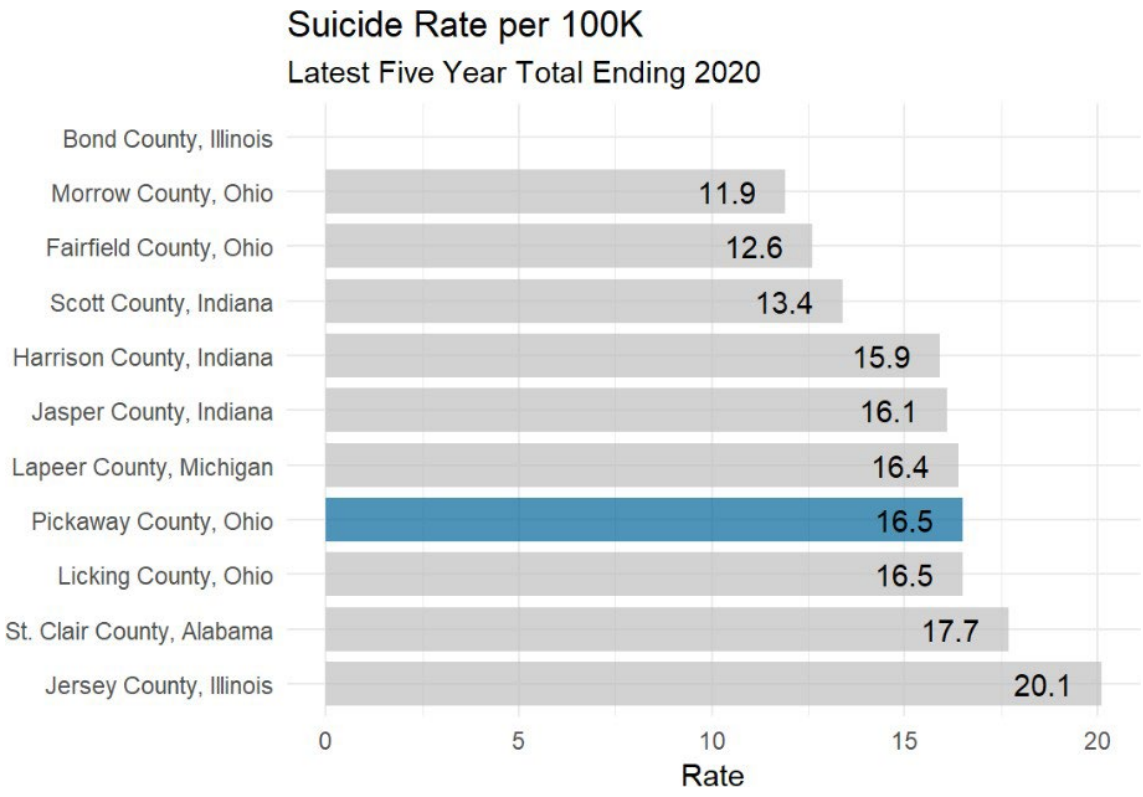
Fayette County



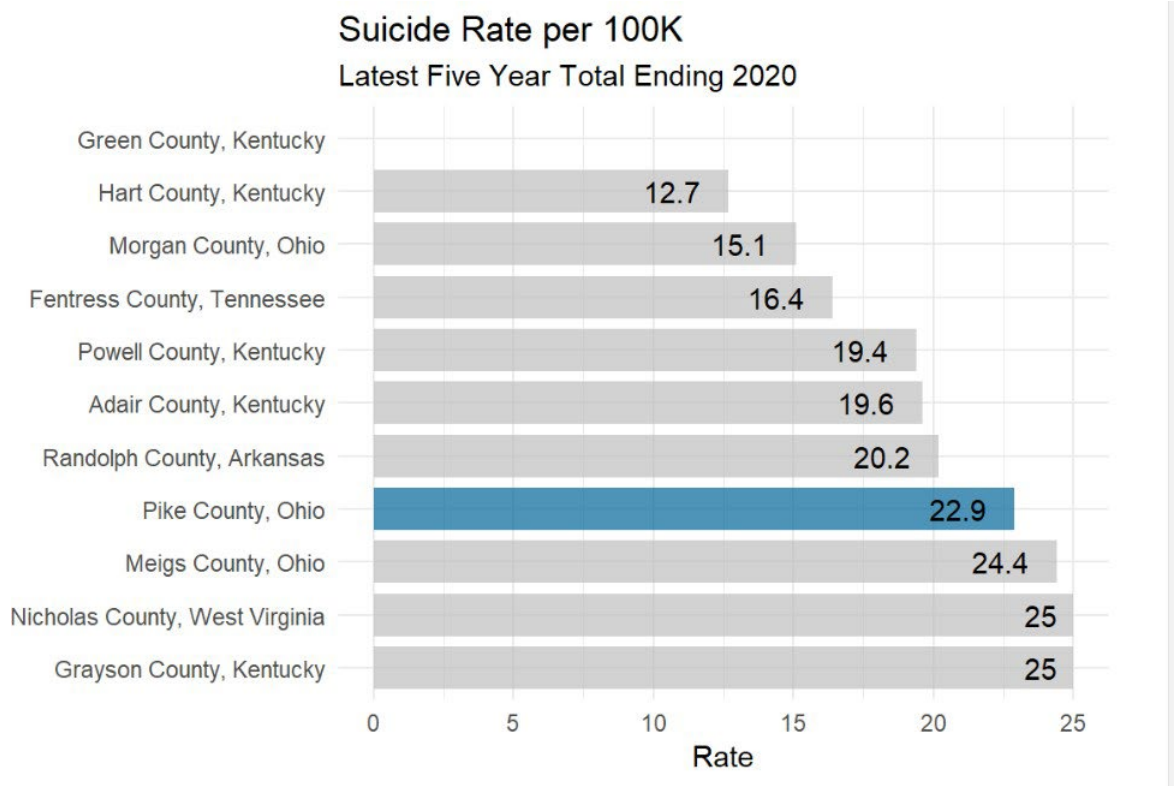
Highland County



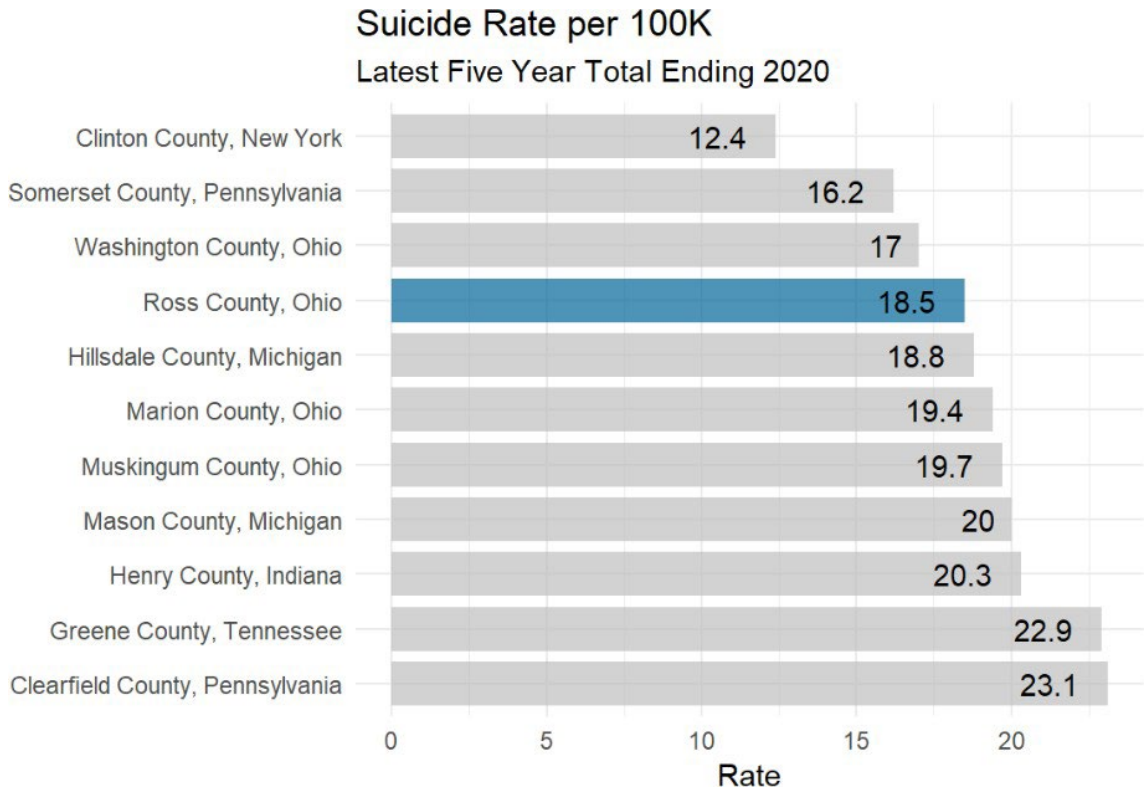
Pickaway County



Pike County



Ross County

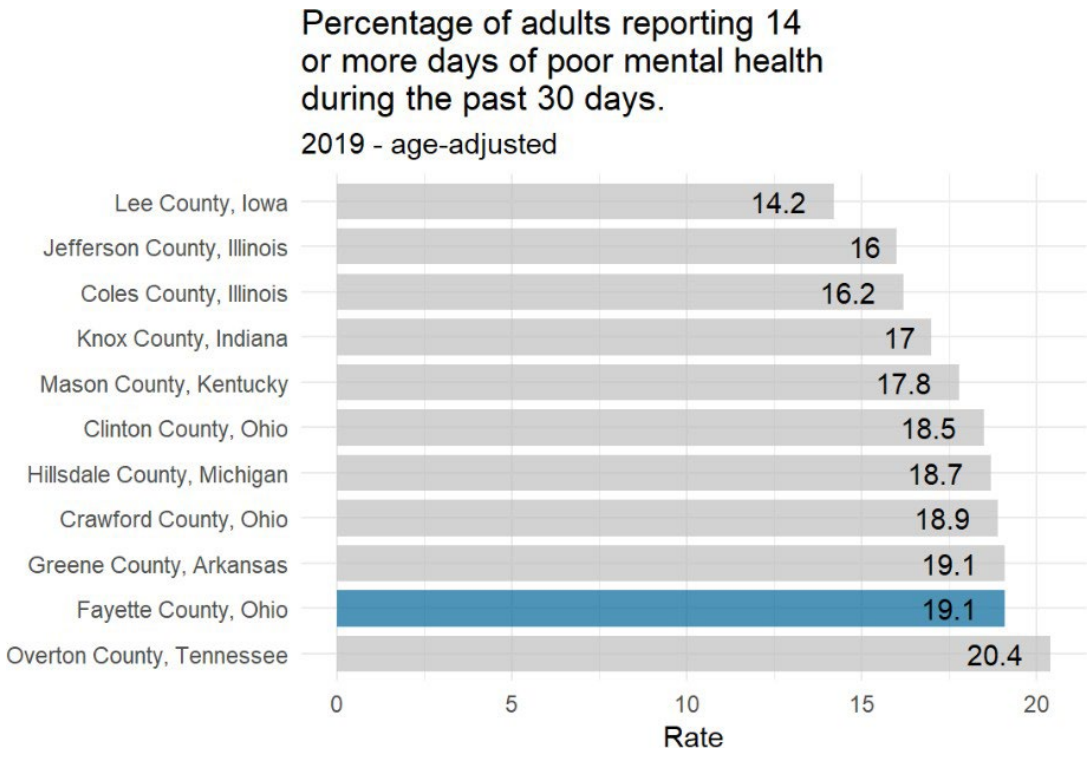


Prolonged Mental Stress The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.[51] BRFSS collected data in 2019, adjusted for age, on adults reporting 14 or more days of poor mental health during the past 30 days. The national average for prolonged mental stress in 2015 was 11.3.[52]

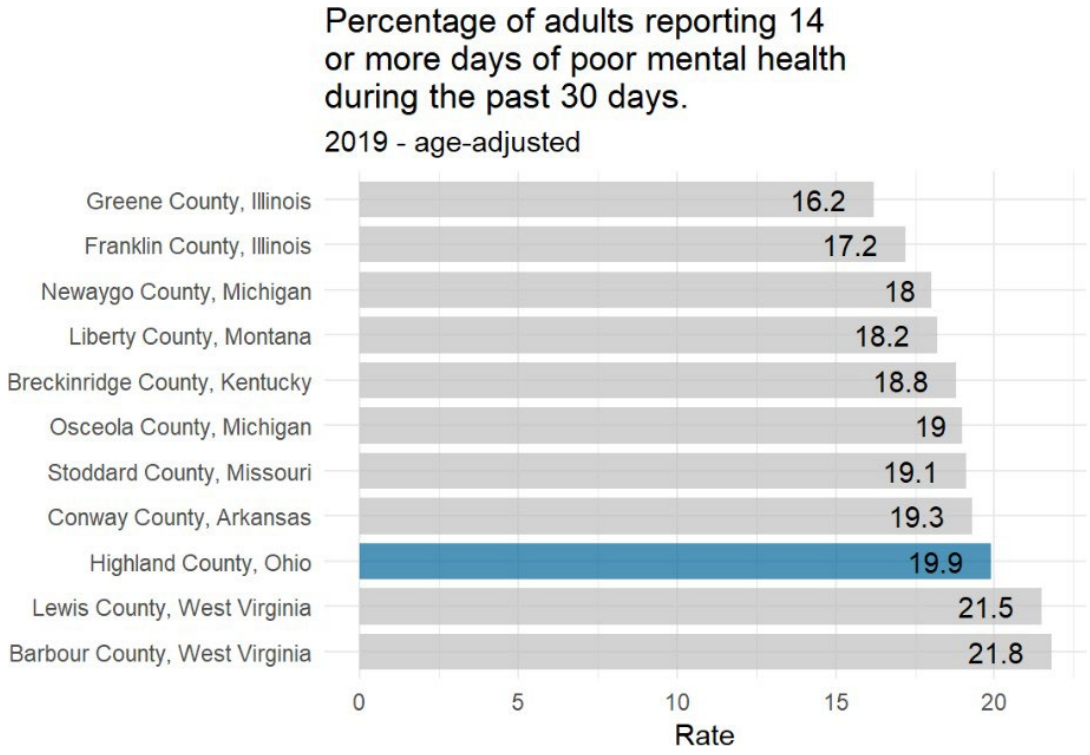
[51] Centers for Disease Control and Preventions. (2022). Behavioral Risk Factor Surveillance System. CDC. https://www.cdc.gov/brfss/index.html

[52] Pickens CM, Pierannunzi C, Garvin W, Town M. Surveillance for Certain Health Behaviors and Conditions Among States and Selected Local Areas — Behavioral Risk Factor Surveillance System, United States, 2015. MMWR Surveill Summ 2018;67(No. SS-9):1–90. DOI: http://dx.doi.org/10.15585/mmwr.ss6709a1

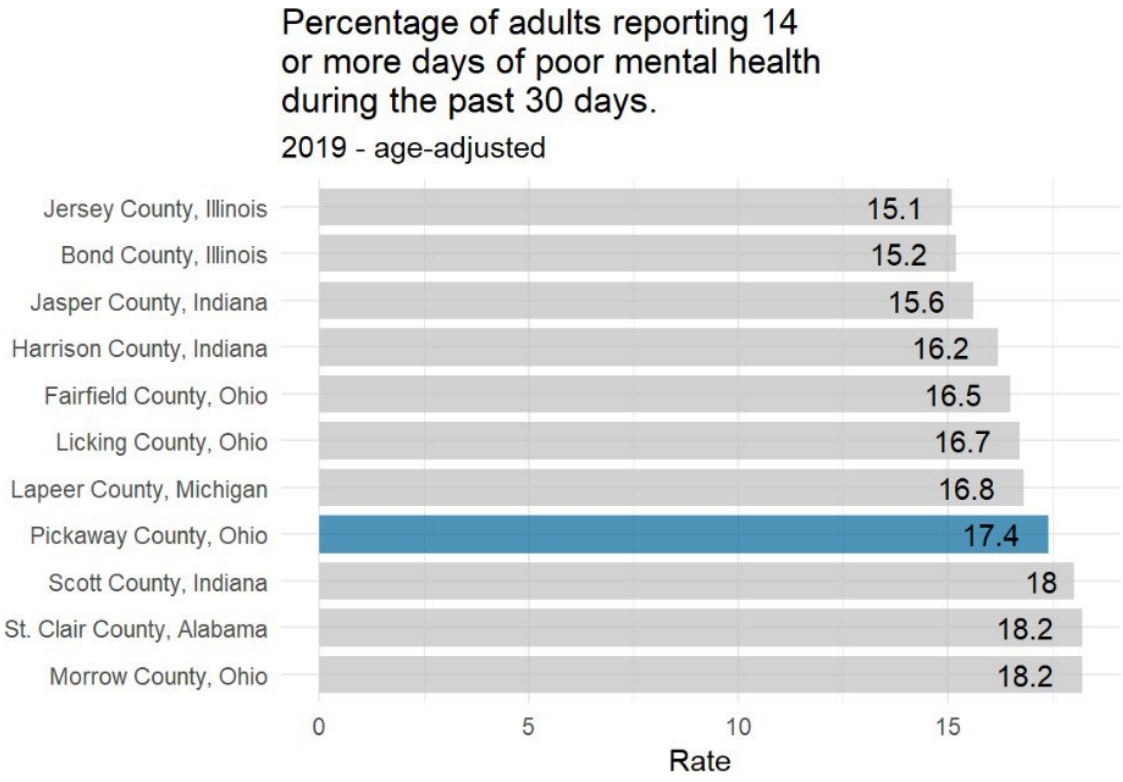
Fayette County



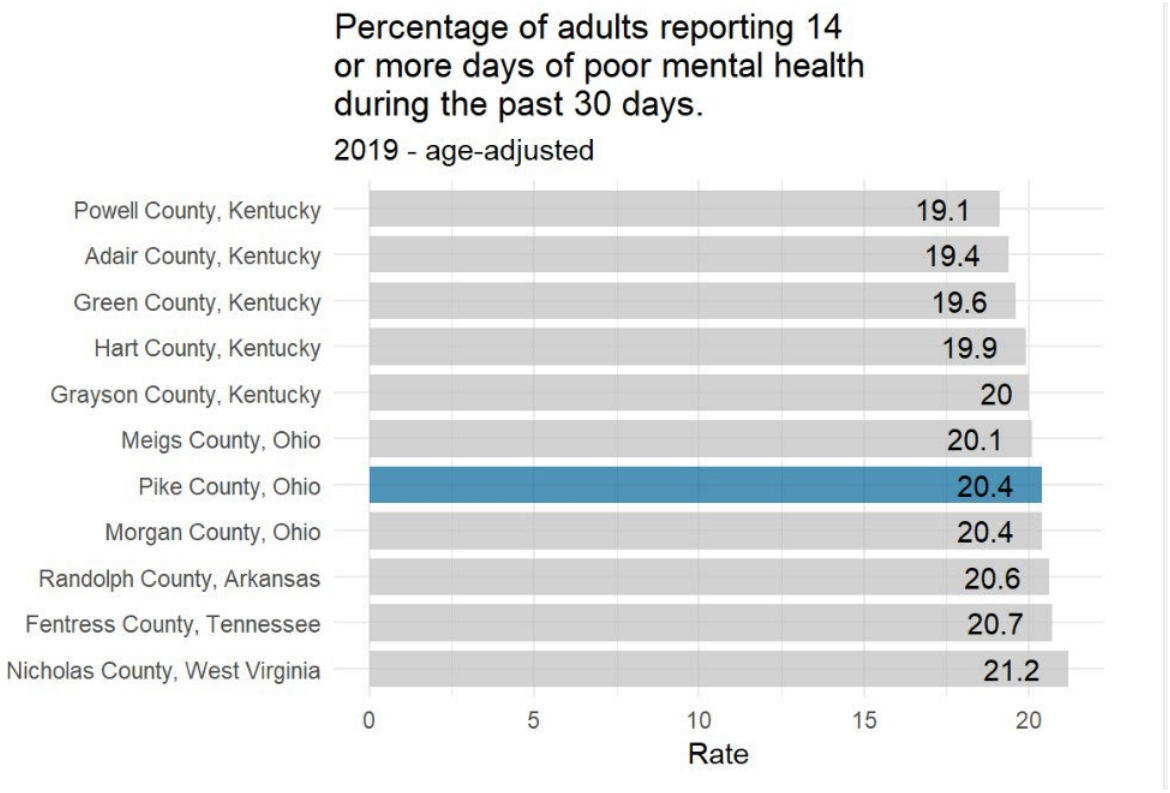
Highland County



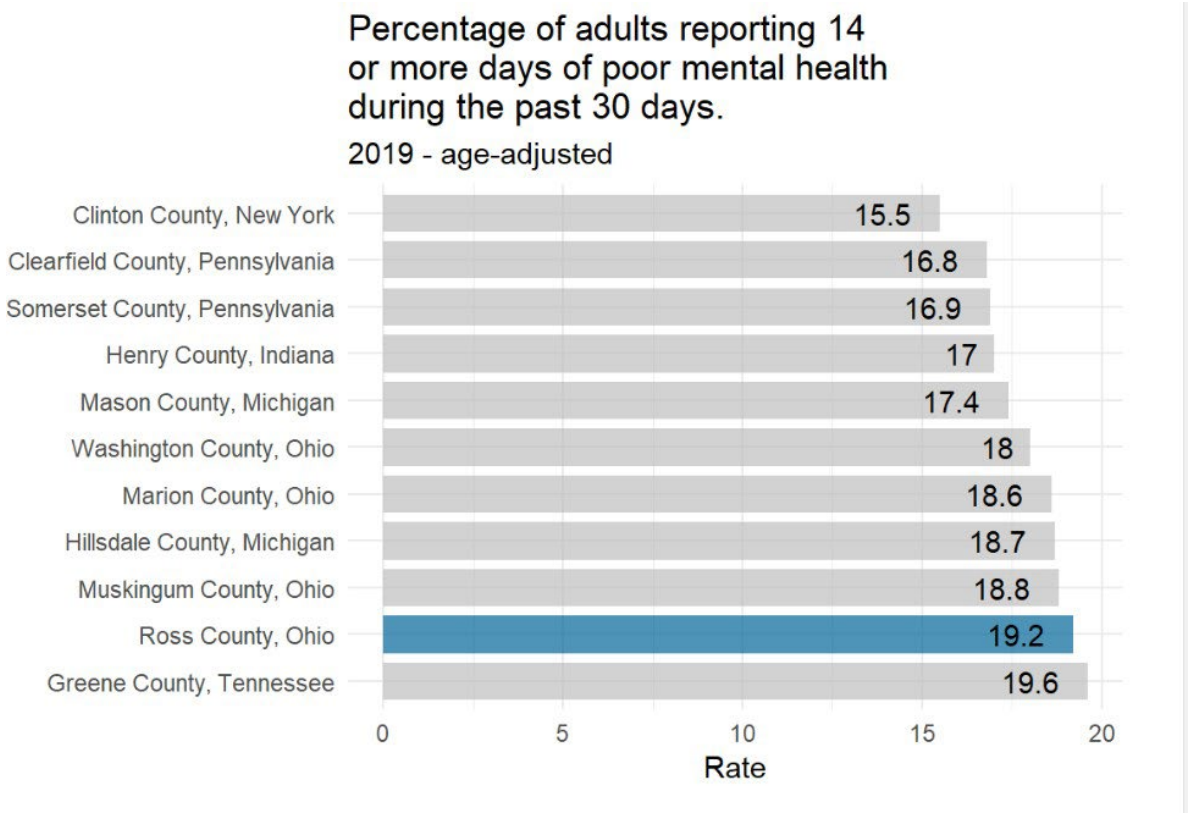
Pickaway County



Pike County

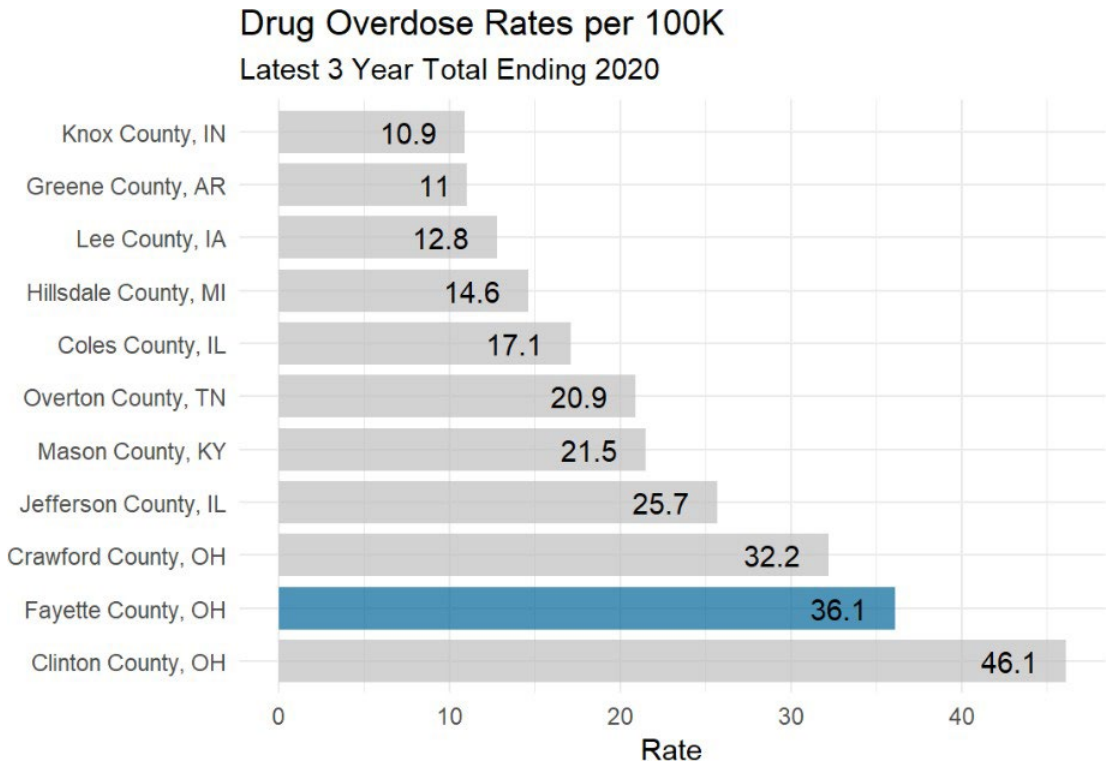


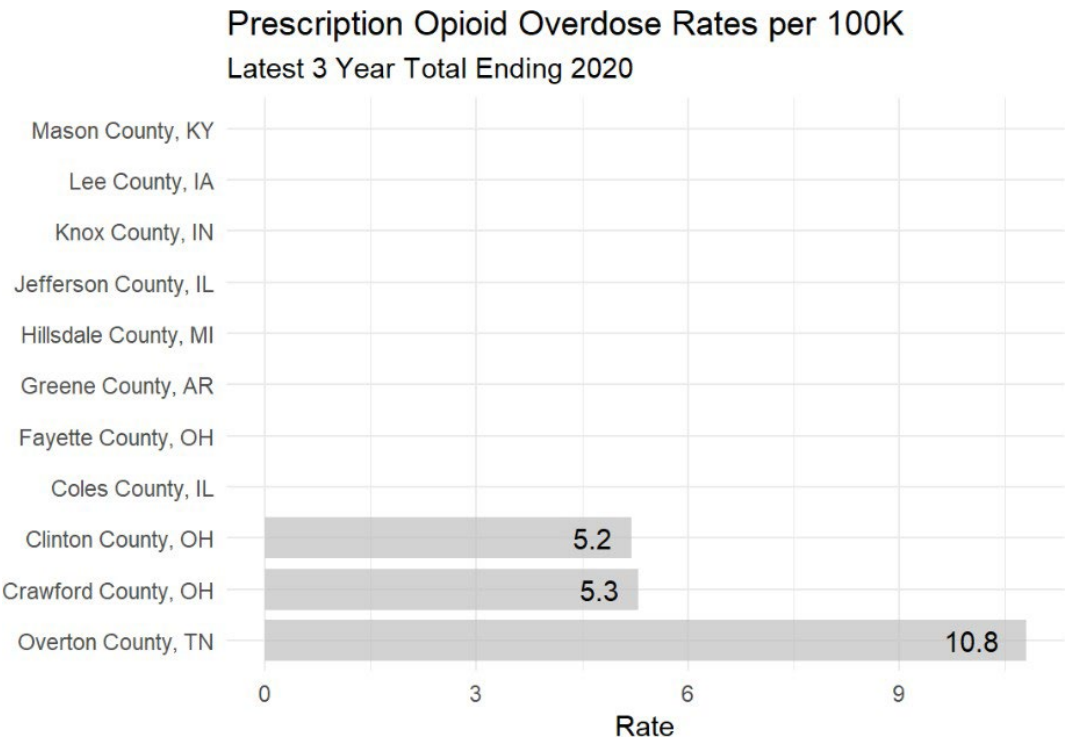
Ross County



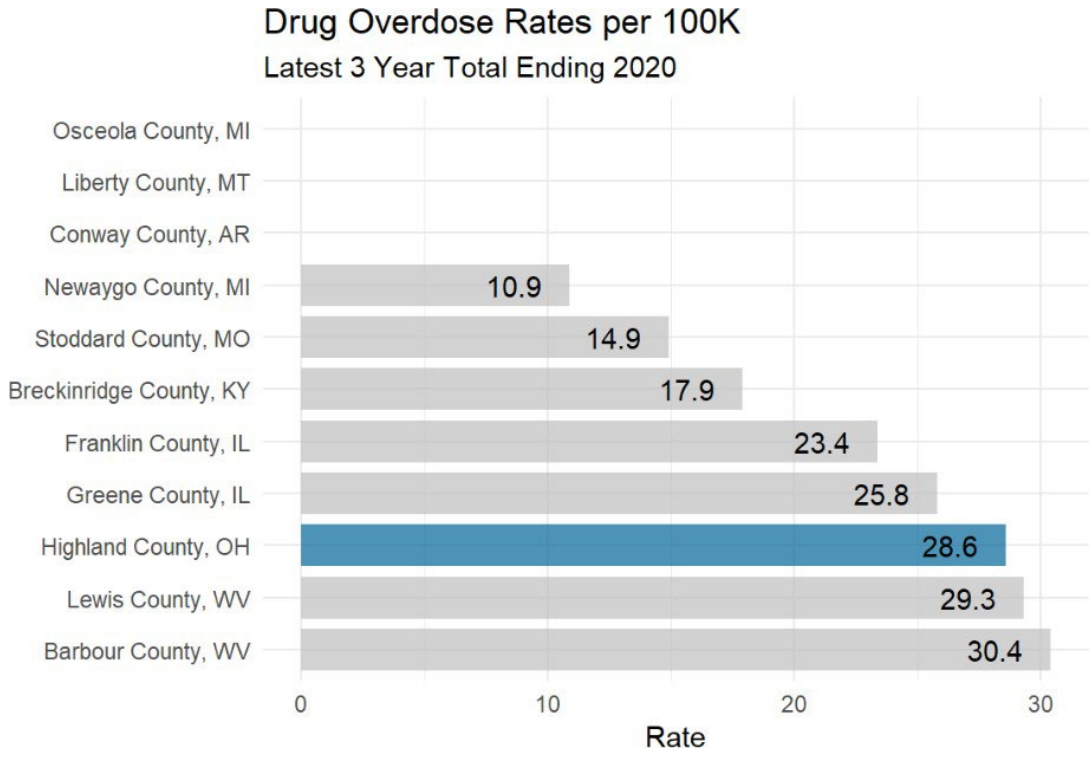
Drug Overdose and Prescription Opioid Overdose Rate The CDC collects data for each county within the United States specific to reported drug and prescription opioid overdose rates per 100,000 people. Rates are averaged from years 2018-2020. The CDC will not provide data for counties whose total drug overdose count is less than 10. In 2019 drug overdose prevalence was 21.6 per 100,000 people.

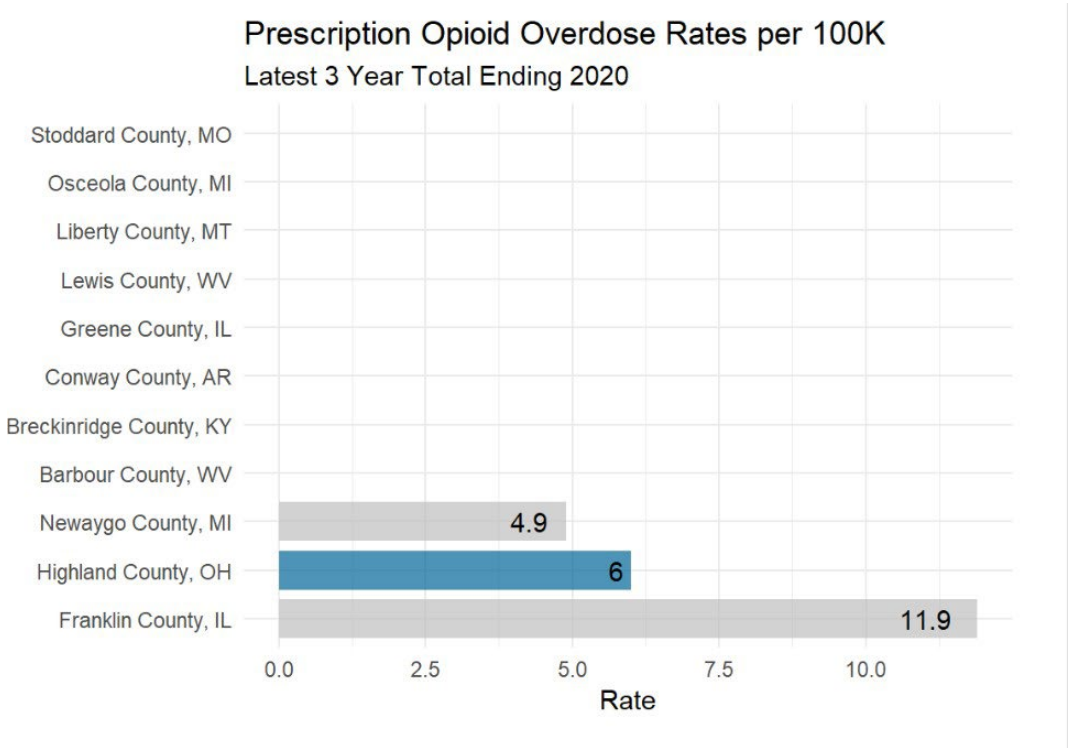
Fayette County



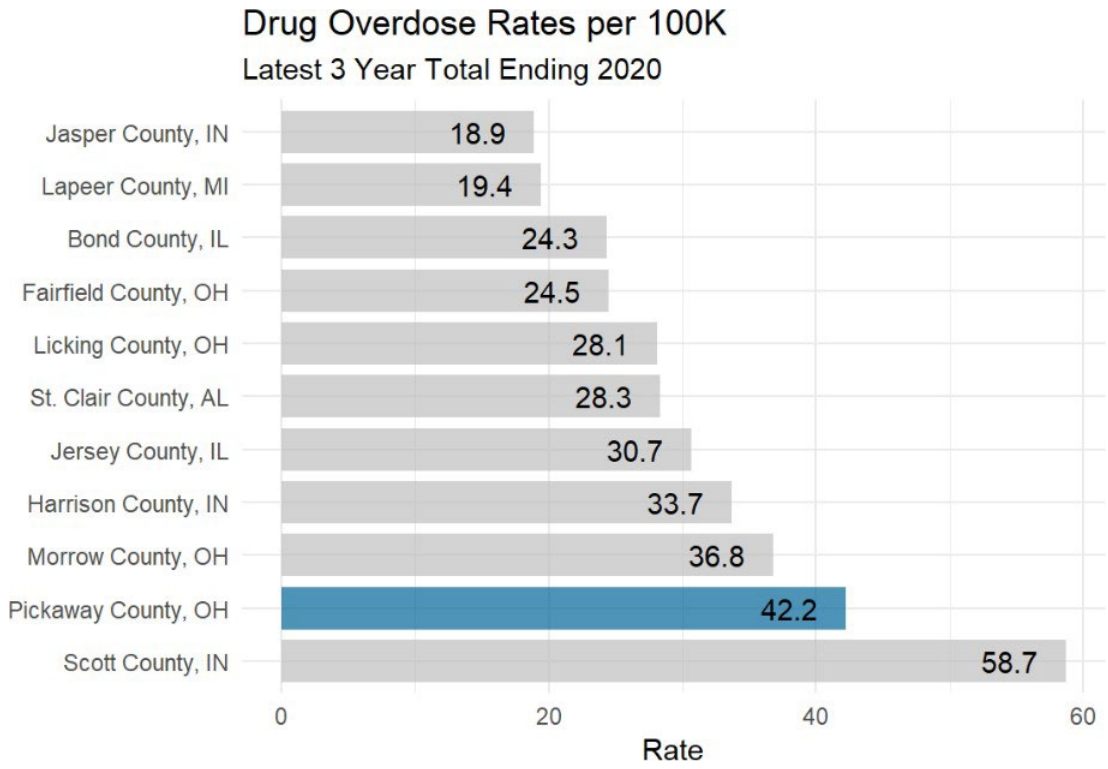


Highland County

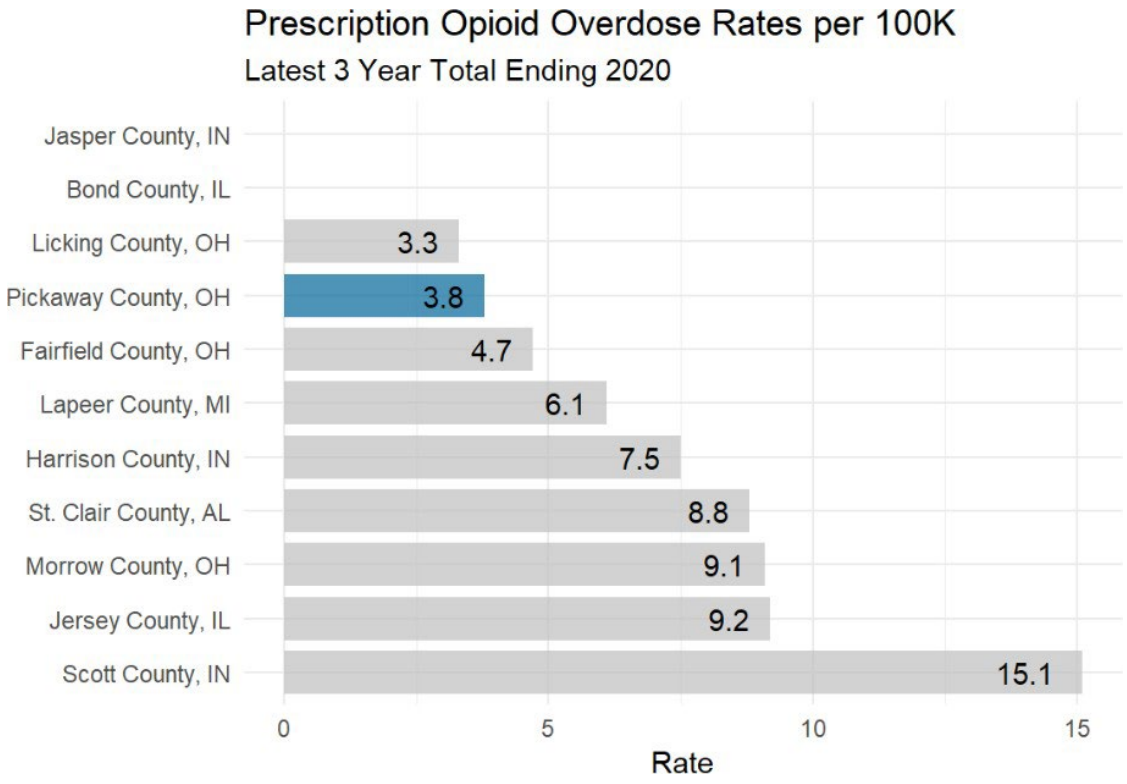


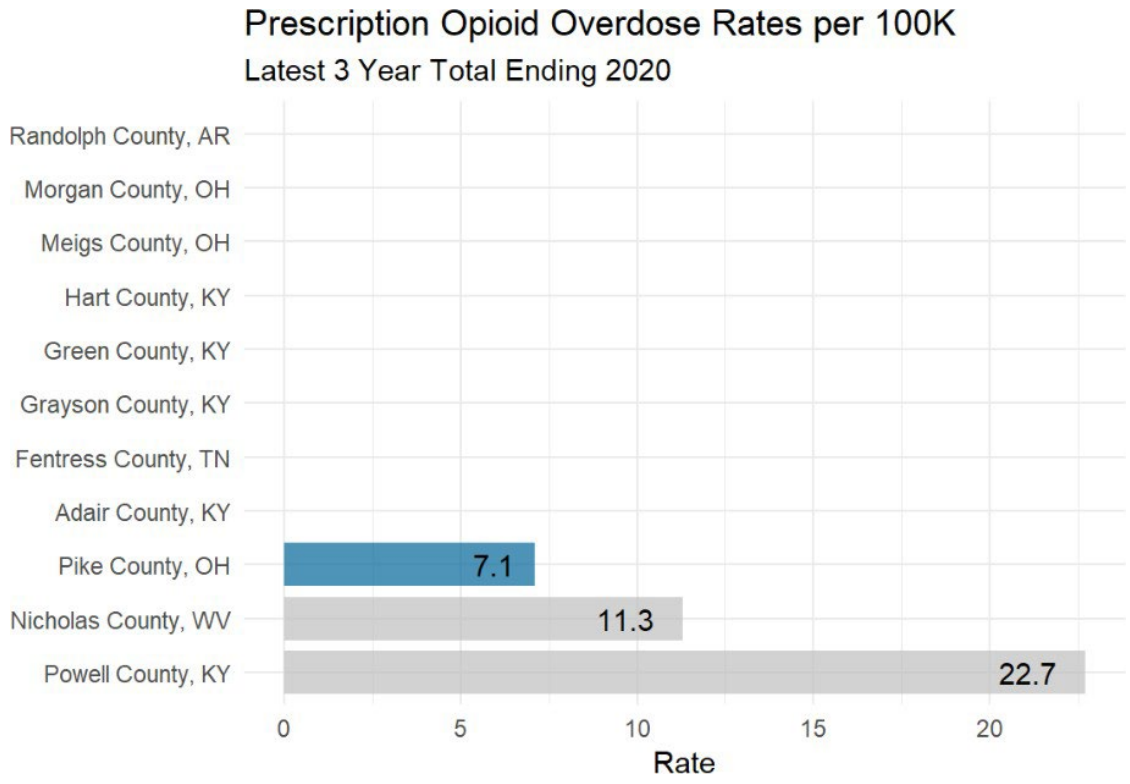


Pickaway County

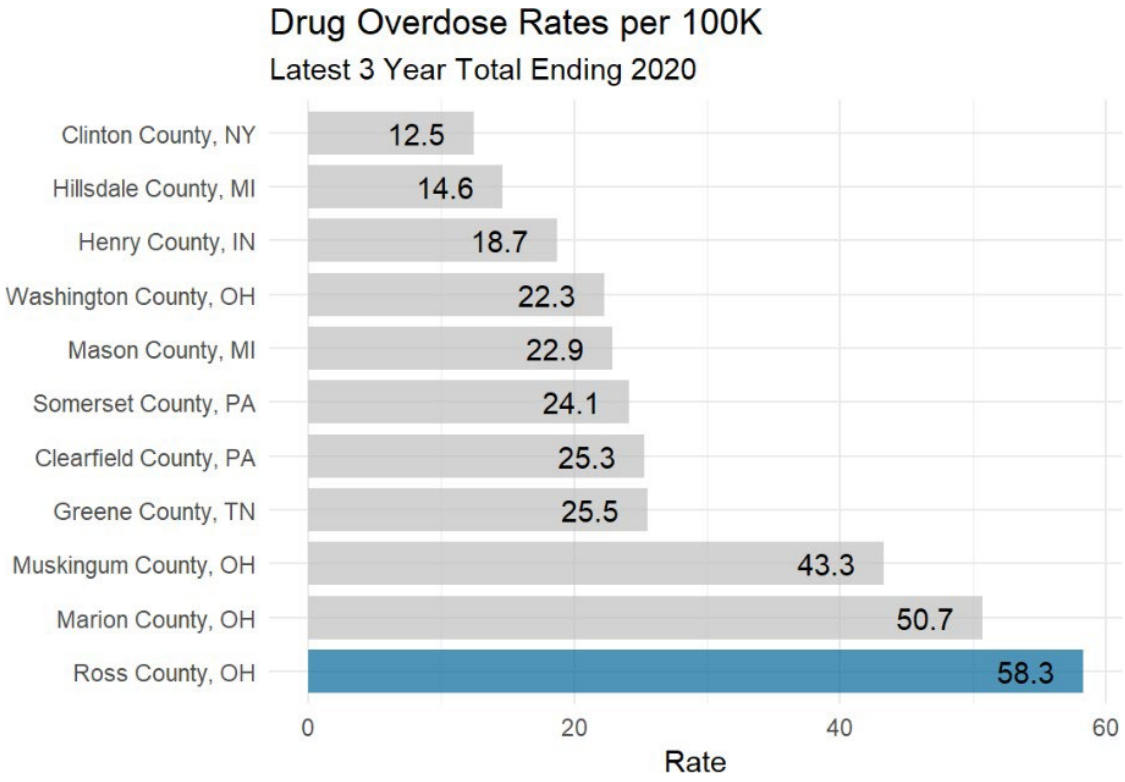


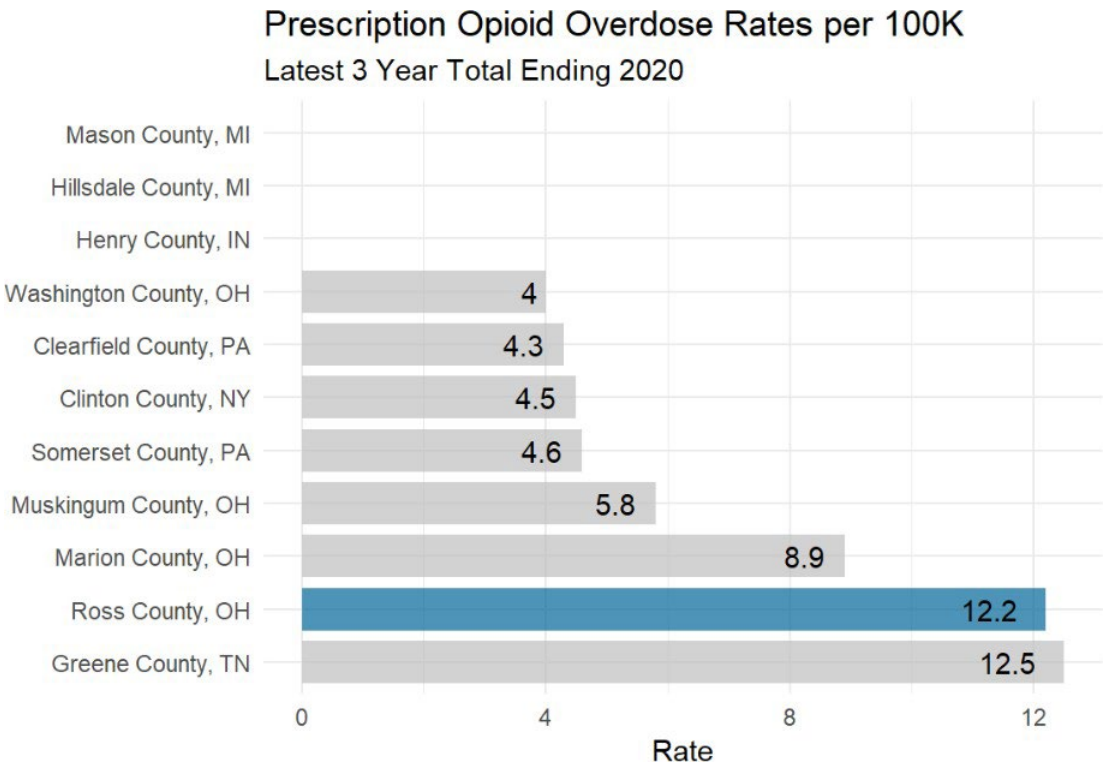
Pike County


Prescription Opioid Overdose Rates per 100K
Latest 3 Year Total Ending 2020
Jasper County, IN
Bond County, IL
Licking County, OH
Pickaway County, OH
Fairfield County, OH
Lapeer County, MI
Harrison County, IN
St. Clair County, AL
Morrow County, OH
Jersey County, IL
Scott County, IN
3.3
3.8
4.7
6.1
7.5
8.8
9.1
9.2
15.1
0
5
10
15
Rate


Prescription Opioid Overdose Rates per 100K
Latest 3 Year Total Ending 2020
Randolph County, AR
Morgan County, OH
Meigs County, OH
Hart County, KY
Green County, KY
Grayson County, KY
Fentress County, TN
Adair County, KY
Pike County, OH
Nicholas County, WV
Powell County, KY
7.1
11.3
22.7
0
5
10
15
20
Rate

Ross County


Drug Overdose Rates per 100K
Latest 3 Year Total Ending 2020
Clinton County, NY
Hillsdale County, MI
Henry County, IN
Washington County, OH
Mason County, MI
Somerset County, PA
Clearfield County, PA
Greene County, TN
Muskingum County, OH
Marion County, OH
Ross County, OH
12.5
14.6
18.7
22.3
22.9
24.1
25.3
25.5
43.3
50.7
58.3
0
20
40
60
Rate


Prescription Opioid Overdose Rates per 100K
Latest 3 Year Total Ending 2020
Mason County, MI
Hillsdale County, MI
Henry County, IN
Washington County, OH
Clearfield County, PA
Clinton County, NY
Somerset County, PA
Muskingum County, OH
Marion County, OH
Ross County, OH
Greene County, TN
4
4.3
4.5
4.6
5.8
8.9
12.2
12.5
0
4
8
12
Rate