Adult Mobile Crisis (AMC) Alternative Payment Model (APM) Program Standards

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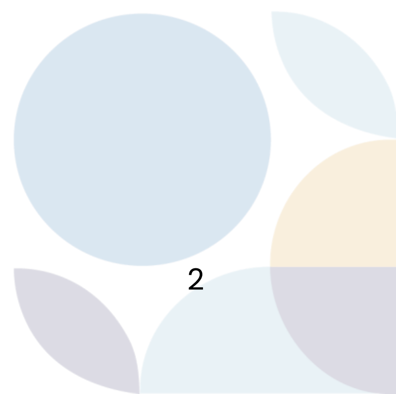

Background and Purpose

Clear Pathways, an initiative of Peg's Foundation, is a statewide systems-change effort focused on transforming how adults experiencing a behavioral health emergency receive help—so that jails, hospitals, and law enforcement are no longer the default response. Clear Pathways works to sustainably align mental health, substance use, emergency response, and community systems to ensure people in crisis have a clear, person-centered path to timely and appropriate care in Ohio and across the nation.

Clear Pathways (CP) aims to align systems and services to connect individuals to behavioral health treatment before a crisis begins, or at the earliest possible stage of systems interaction. To achieve this, we engage in four core areas of systems-change activities: piloting innovations, building capacity, improving policies, and generating knowledge.

In 2024, CP Clear conducted a comprehensive 20-state policy analysis to examine how states across the country structured adult mobile crisis (AMC) and other crisis benefits. This included review of Medicaid state plan amendments, Medicaid managed care organization (MCO) contracts, coverage guidance, provider manuals, rate-setting approaches, and regulatory frameworks. The analysis assessed:

- Whether and how AMC services were explicitly defined in policy
- Required service components (e.g., screening, mobile response, follow-up)
- Workforce and team composition requirements
- Billing structures and payment methodologies
- Data, reporting, and quality measurement expectations

Our analysis revealed significant variation across states and confirmed that states with clearer service definitions and expectations were better positioned to support sustainable reimbursement, evaluate outcomes, and experiment with value-based payment approaches.

In Ohio, AMC services are largely funded by local Alcohol, Drug, and Mental Health (ADAMH) Boards, despite being a Medicaid-coverable service. In the absence of a clearly defined AMC benefit, Boards have developed and financed mobile crisis services in different ways, resulting in significant variation in service models, payment approaches, and expectations. Providers have operated within this fragmented landscape without a consistent service definition, limiting

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standardization, data comparability, and the ability to assess cost, utilization, and outcomes across programs.

Clear Pathways developed these draft AMC program standards in response to Ohio's lack of a visible, clearly defined AMC benefit. Establishing shared standards is essential to create a consistent service definition, reduce variation across providers, and make it possible to credibly test an alternative payment model (APM) for AMC.

Building on multi-state policy analysis and national guidance, the standards define core service components, staffing, and quality expectations, enabling standardized data collection, meaningful cost and utilization analysis, and value-based payment testing.

The AMC APM Demonstration will use this foundation to test value-based payment approaches aimed at improving access, quality, and continuity of care while reducing avoidable hospital and justice system involvement.

Overview

This document establishes the AMC service model and draft program standards for the Clear Pathways AMC AMP Demonstration. Standards define core service components, response expectations, staffing and competency requirements, continuum-of-care collaboration, and quality and data expectations, providing a standardized framework to guide implementation, promote consistency, and support the implementation and testing of an APM for AMC.

The AMC practice standards were developed through a collaborative process that included stakeholder interviews, surveys, and listening sessions with Ohio Department of Behavioral Health (DBH) staff, county board authorities, service providers, peer supporters, families, and national experts. The standards integrate national best and promising practices informed by SAMHSA guidance, recommendations from the Ohio Crisis Task Force (2022–2023), qualitative analysis of adult mobile crisis programs operating in Ohio, and a multi-state policy review of states with a statewide mobile crisis benefit. Together, these inputs ensure the standards reflect current practice realities and Ohio's policy context.

According to the Substance Abuse and Mental Health Services Administration's 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care, multiple studies have demonstrated the effectiveness of mobile crisis services. As noted by SAMHSA (2025),

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Multiple studies have provided empirical evidence on the effectiveness of mobile crisis services. These studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, linking individuals with suicidal ideation discharged from the emergency department (ED) to services, and are more effective than hospitalization at linking people in crisis to outpatient services.

In addition, one study that evaluated the cost-effectiveness of mobile crisis services found that mobile crisis programs resulted in a 23 percent lower average cost per case when compared to regular law enforcement intervention (Scott, 2000). Another study examining the cost impact of mobile crisis intervention services found that such services can reduce costs associated with inpatient hospitalization by approximately 79 percent during a six-month follow-up period after the crisis episode (Bengelsdorf & Alden, 1987).

AMC Definition

AMC is a structured, community-based, in-person service for adults experiencing a behavioral health crisis. It is a diversion-focused model designed to provide timely assessment, de-escalation, and short-term intervention, facilitate access to appropriate care across the continuum, and help individuals avoid unnecessary hospitalization or involvement with law enforcement whenever safe and appropriate.

Service Model

Because options for assistance can be limited when adults experience a behavioral health crisis, individuals and family members often utilize the options available to them, such as calling 911 to trigger law enforcement and/or emergency response, or choosing to access acute services, like hospital emergency departments and inpatient treatment for help. The AMC delivery model is designed to prevent: 1) the unnecessary use of emergency departments or acute care services; 2) prevent unnecessary psychiatric inpatient placements; 3) unnecessary involvement of law enforcement or emergency medical services; and/or 4) involvement in the criminal legal system.

AMC delivers timely, community-based intervention for adults experiencing a behavioral health crisis. Services are provided where the crisis occurs or at another community location requested by the individual, family, or referrer, and are not delivered in office-based, hospital, or other acute care settings.

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AMC teams provide onsite assessment, de-escalation, and short-term intervention. When an individual is determined not to be safe to remain in the community, authorized health officers may initiate involuntary holds to facilitate transition to higher-acuity settings when necessary. AMC services may also include follow-up outreach following the immediate onsite response.

AMC Goals

- Provide immediate intervention to assist adults experiencing a behavioral health emergency.
- Offer specialized BH response to provide trauma-informed, person-centered, recovery-oriented care.
- Reduce the reliance on law enforcement and emergency rooms for BH crisis episodes.
- Effectively engage, assess, deliver, and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve life functioning.
- Provide timely community-based interventions, safety planning, and resource development.
- Mitigate risk and increase safety.
- Prevent/reduce the need for care in more restrictive settings, such as inpatient psychiatric units or correctional facilities.
- Support the adult to remain in, or return to, their present living arrangement and function in community settings.
- Improve individual's skills to manage behavior and prevent future crises.
- Facilitate the adult's transition into identified support, resources, and services; evidence-based and promising community-based treatment services; community-based supports; and natural resources.

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Continuum of Care Collaboration

The AMC model requires collaboration across community systems with linkages between behavioral health agencies and programs, including across administrative and funding boundaries. In order to best serve their communities, AMC programs are routinely expected to develop and maintain relationships with public safety answering points (PSAPs), first responders, including law enforcement and emergency medical services (EMS), as well as local hospitals and judicial systems.

AMC exists within a continuum of care, the primary goal of which is to evaluate the situation for safety and find an appropriate means or setting to support the

individual in crisis to stabilize. As the AMC program supports a person's ability to achieve greater stabilization from the crisis situation, it is essential that a well-developed continuum is available within the community to refer the individual for ongoing support and services. In conjunction with other providers and system partners, the AMC provider will develop a plan for ongoing supports and services as the individual is triaged and assessed and/or served by an immediate crisis outreach and subsequent follow-up activities to address the underlying difficulties that led to crisis and to avert future behavioral health emergencies.

AMC Service Delivery

AMC consists of three phases:

1. Screening and Triage
2. Immediate Onsite Response
3. Non-Immediate Follow-Up

Individuals may receive an immediate onsite response based on screening and triage.

Screening and Triage

When a call for AMC is received by a public safety answering point (PSAP), 988 call center, local crisis line, AMC provider, or other referral source(s), the person receiving the call will conduct a brief triage to determine the appropriate response, including the type of responder, whether an AMC dispatch is warranted, and the urgency of dispatch. As long as the AMC provider has an opportunity to screen and triage the potential response, the referral source or telephonic point of entry for the individual in crisis could be self-requested, requested by a family member, requested by a public safety officer or emergency medical services, or other community member.

Following screening and triage, individuals determined appropriate for Adult Mobile Crisis services should receive an immediate onsite AMC response. Situations requiring law enforcement or emergency medical services (EMS) involvement are

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classified as emergencies, while individuals with non-immediate, non-urgent needs should be directed to appropriate alternative services rather than AMC.

Immediate Onsite Response

An immediate onsite response involves deployment of AMC to the location of the crisis within 60 minutes (120 minutes for rural service areas) of when an immediate mobile response is determined appropriate by the AMC provider or request is made by law enforcement or other first responders.

The immediate face-to-face response serves several core purposes: assessing the situation, supporting de-escalation, and establishing safety. The responding AMC practitioner(s) should actively draw on the strengths and perspectives of the adult, their family, and close support as part of the response. Before leaving the initial visit, the practitioner(s) will establish a safety plan, identify next steps, and arrange follow-up care.

During the immediate onsite response, the following are performed:

- ***Assessment of immediate safety concerns.*** Upon arriving on-scene, mobile responders will assess immediate safety concerns, as well as violence and risk factors. This could include presence of a weapon, signs of a potential medical emergency, erratic behavior that threatens responder safety, signs of domestic abuse, signs of sexual violence or danger, or other signs of danger to individuals, mobile responders, or others in the vicinity of the situation.
- ***Address immediate safety concerns.*** Mobile responders will make initial determination on the need for coordination and dispatch of law enforcement or EMS providers. If the situation is deemed unsafe, mobile responders will contact supervisors to provide an update on the situation and evacuate the scene until first responders arrive.
- ***Crisis assessment.*** Provision of an urgent assessment and brief history of the current BH emergency situation. Evaluation should assess the presenting problem, the risk of harm to self and others, the use of alcohol or drugs, the treatment history for mental illness or substance use, a medical history and examination (mental status or physical), and other psychosocial factors that may contribute to the current crisis (e.g., current or historical trauma, family involvement, conflicts and support, legal involvement, vocational functioning, and presence or lack of social supports).
- ***Mental status and substance use exam.*** The assessment will include, but not be limited to, current risk level related to suicide/homicide, substance use,

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mental status, current and past mental health diagnoses and treatment, coping skills and medical condition.

- ***De-escalate the crisis.*** In-person interventions for immediate de-escalation of presenting behavioral symptoms using evidence-based interventions to minimize the potential for psychological, physical, or emotion trauma.
- ***Stabilization.*** Mobilization of resources and crisis intervention techniques to defuse the crisis and restore safety to the individual and others.
- ***Support transition to higher level of care (when appropriate).*** In the event that the individual in crisis cannot be stabilized by the responding mobile crisis team in the community, services may also include facilitation of a safe transition to a higher level of care. In addition, individuals in crisis may also be transferred to a lower level of care. The transition may include, but is not limited to, warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations and/or higher levels of care, such as a community-based crisis facility or hospital emergency department. This activity also includes determination of need for an involuntary hold. If an involuntary hold is deemed necessary, coordinate transportation to an acute setting, such as a hospital emergency department or community-based crisis facility.
- ***Establish an initial safety plan.*** Engagement of the individual in a crisis planning process, resulting in the creation of an initial safety plan. This plan would be created with provision or consultation by an independent BH practitioner or BH professional under supervision to document an initial safety plan. The initial safety plan aims to keep an individual in crisis and their environment safe, and may include lethal-means counseling, identification of safety strategies, and other evidence-based crisis safety tools and techniques. This initial safety plan also includes identification of individualized supports or care coordination for physical healthcare, behavioral healthcare, and social services to assist with the individual's needs and ongoing service planning. The initial safety plan, as appropriate, should be developed with input from individuals or caregivers related by blood or affinity whose close association with the person is the equivalent of a family relationship as identified by the person including kinship and foster care.
- ***Linkages to services and supports.*** Referral and linkage to other healthcare, behavioral healthcare, and social services to avoid more restrictive levels of treatment.
- ***Provision or coordination of transportation of individuals in crisis.*** When clinically indicated, connect and coordinate transportation for the individual to an appropriate facility for further care. In these cases, AMC teams shall provide or coordinate transportation to the nearest appropriate facility

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capable of triaging, stabilizing, and determining clinically appropriate level of care.

Face-to-Face Exceptions

The immediate onsite response requires face-to-face engagement with the individual in crisis. There may be rare exceptions or extenuating circumstances where an initial crisis outreach is delivered in a telehealth capacity, such as a public health emergency, natural disaster, inclement weather, or other factors. Such exceptions should be documented for justification of service need and delivery.

Non-Immediate Follow-Up

Following the immediate onsite response (post 72-hours), an individual may be determined by the AMC provider to need a non-immediate follow-up with the goal of ensuring individuals remain safe in the community. Non-immediate follow-up could include face-to-face engagement or telehealth/telephonic engagement based on the needs of the individual. Non-immediate follow-up can occur for up to 7 days following an immediate onsite response.

Non-immediate follow-up mobile outreach activities may include, but are not limited to:

- Continued assessment and ongoing monitoring of the safety plan
- Reassessment of risk factors, including potential for future BH crisis episodes.
- Solution-focused interventions
- Counseling and psychotherapy
- Teaching new communication, problem solving, coping and behavior management skills
- Psychoeducation
- System navigation
- Referral for psychiatric consultation and medication management if indicated.
- Advocacy and networking by the provider to establish linkages and referrals to appropriate natural and clinical support and services that will sustain engagement post AMC.
- Coordination of specialized services to address the needs of adults with co-occurring intellectual/developmental disabilities and substance use

During immediate or non-immediate follow-up mobile outreach, the AMC practitioner will work with the individual to identify and link to formal (when necessary), informal

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and natural supports that will engage the person after they have transitioned out of the immediate mobile response or non-immediate follow-up mobile outreach phase.

Administration

Provider Certification

To be certified as an AMC provider, a community mental health services or addiction services provider must have the following DBH certifications:

- General services as defined in rule 5122-29-03 of the Ohio Administrative Code.
- Substance Use Disorder (SUD) case management services as defined in rule 5122-29-13 of the Ohio Administrative Code.
- Peer recovery services as defined in rule 5122-29-15 of the Ohio Administrative Code.
- Community psychiatric supportive treatment as defined in rule 5122-29-17 of the Ohio Administrative Code.
- Therapeutic behavioral services and psychosocial rehabilitation as defined in rule 5122-29-18 of the Ohio Administrative Code.
- The community mental health services or addiction services provider must be able to provide all allowable services by telehealth as defined in rule 5122-29-31 of the Ohio Administrative Code.

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AMC Staffing

AMC providers must maintain a fully developed, multidisciplinary staffing model with the capacity to deliver appropriate care at the appropriate time. At a minimum, this includes independently or dependently licensed clinical staff, with access to an appropriately credentialed supervisor during AMC operating hours, who are authorized under their professional scope of practice to conduct clinical assessments and determine level of care for mental health and substance use conditions.

AMC providers must have policies and procedures in place to ensure safety of all staff who respond to crisis situations in the community, including when to involve or refer to law enforcement using established protocols and communication methods.

AMC providers must have:

- A clinician identified in rule 5122-29-30 of the Ohio Administrative Code who holds a valid and unrestricted certification or license issued by any of the Ohio professional boards that includes a scope of practice for mental health and substance use disorder conditions. Neither a qualified behavioral health specialist (QBHS) as defined in rule 5122-29-30 of the Administrative Code, nor a peer supporter certified pursuant to rule 5122-29-15.1 of the Administrative Code meets the standards of this paragraph; and
- An Adult Peer Supporter who holds a valid and unrestricted certification from DBH issued in accordance with rule 5122-29-15.1 of the Ohio Administrative Code or a QBHS as defined in rule 5122-29-30 of the Administrative Code.
- Access to an individual who can initiate an Application for Emergency Admission ("pink slip" or "involuntary hold") as appropriate as identified in Ohio Revised Code 5122.10.

Licensed Behavioral Health Staff Responsibilities

- Provide screening and, at minimum, brief assessment, inclusive of a risk and suicidality assessment for the adult in crisis (appropriate assessment discussed in subsequent section).
- De-escalate the presenting crisis during the immediate crisis response.
- Create an initial safety plan with the individual being served.
- Determine what other types of services are, or if a higher level of care is needed.
- Ensure services are culturally appropriate and in language of origin of the person.
- Connect individuals to facility-based care as needed, through warm handoffs and coordination of transportation.

Peer Supporter or Qualified Behavioral Health Specialist (QBHS) Responsibilities

During the initial mobile response or as part of AMC non-immediate follow-up mobile outreach, peer support and/or QBHS are expected to:

- Use lived experience to assist individual (peer supporters)
- Provide immediate mobile response and non-immediate follow-up responses as available and within scope of practice.
- Attempt to establish a trusting relationship with the individual.

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- Collaborate with all AMC team members to define and achieve individual goals or goals that are identified in the safety plan.
- Work with the individual to ensure that the care plan is representative of their values and needs.
- Crisis response and de-escalation
- Provide resource linkages and referrals.
- Identify natural resources within the community that can be helpful.
- Work with the individual to access and utilize cultural supports.

Supervision

Individuals are eligible to provide and supervise within their professional scope of practice those services described within this document. Licensed, certified or registered individuals shall comply with current, applicable scope of practice, supervisory, and ethical requirements identified by appropriate licensing, certifying or registering bodies.

Program and Staff Core Competencies

The AMC provider will ensure that all practitioners complete all required training. Training will include core training modules and additional training modules delivered at various times and locations throughout the year.

AMC services are expected to follow national, and state best practices related to:

- Cultural and Linguistic Competency
- Trauma-Informed Care Service Delivery
- Co-Occurring Capable

Staffing levels will be established as necessary to achieve the key benchmarks of response time, mobility, the provision of stabilization services and ongoing engagement, as necessary. There should be capacity to respond to multiple calls for AMC services at the same time.

AMC may develop and maintain contractual agreements as necessary to maintain AMC service capacity for the designated region. Such arrangements may include subcontracts with other behavioral health providers, identified as Designated Collaborating Organizations (DCOs), to provide staffing to fulfill AMC functions. DCOs involved in direct delivery of AMC services must have appropriate training, credentials, and certification for mobile response program staff.

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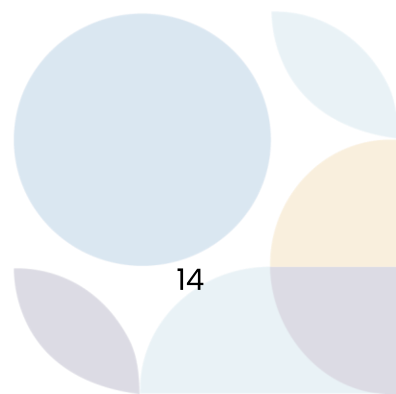

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About Clear Pathways

Clear Pathways is an initiative of Peg's Foundation designed to sustainably align systems for improved care to individuals experiencing a behavioral health crisis.
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