CLEAR PATHWAYS
An Initiative of Peg's Foundation

Adult Mobile Crisis

Alternative Payment Model Demonstration

April 13, 2026

Clear Pathways Theory of Change

We Focus Our Efforts in Four Areas

Pilot Innovations

- Achieve 911/988 interoperability by promoting shared governance, call transfer protocols, and data sharing.
- Develop evidence-based alternative crisis response models.
- Use community-centered frameworks and iterative learning approaches.

Build Capacity

- Assess crisis services across the continuum of care for needs.
- Share emerging, best, and promising practices with the field.
- Foster community readiness by engaging diverse participants.

Improve Policies

- Assess opportunities to influence crisis response service regulatory policies.
- Create model policy language to improve crisis response services.
- Design payment and service innovations.

Generate Knowledge

- Track performance, measure impact, and embed learning to build evidence.
- Build necessary infrastructure to generate high-quality evidence.
- Engage people with lived, practical, and technical expertise to enhance insights.

By Employing Key Strategies

To Achieve Long-Term Outcomes

- Improved access to the right level of behavioral health care at the right time.
- Reduced reliance on emergency departments and inpatient hospitalizations for crisis care.
- Reduced unnecessary law enforcement involvement.
- Improved experiences with the behavioral health system.
- Improved well-being of adults with behavioral health conditions.
- Decreased risk of death by suicide.
- Sustainably-funded behavioral health crisis system.

And Realize Our Impact of Adults With a Behavioral Health Condition Living a Meaningful Life in the Community

Our Mission

Clear Pathways assists local, state, and national partners with accelerating the implementation of best-practice behavioral health crisis response to reduce reliance on jails and hospitals, ensuring adults have a clear path to getting person-centered help.

Our Vision

Our vision is for people experiencing behavioral health crises to have a clear path to help, across Ohio and the nation.

Our Assumptions

- Adults with a behavioral health condition can and do recover.
- Services that incorporate crisis best practices and are tailored to local needs are essential.
- Partnerships and collaboration strengthen crisis response policies, protocols, and practices.
- Communities want to transform behavioral health crisis response and can do so if they have trained staff, technical support, and sustainable funding.
- People with diverse lived expertise are essential to transforming behavioral health crisis response.
- Evidence-informed decision-making is vital to a high-quality behavioral health crisis response system.

What Is Adult Mobile Crisis

- Adult mobile crisis (AMC) is a **structured, community-based, in-person intervention** for adults experiencing a behavioral health emergency.
  - It is a diversion-focused model that facilitates timely access to behavioral health services across the continuum of care.
- AMC provides **immediate assessment and intervention** for adults experiencing behavioral health emergencies with the goals of:
  - stabilizing individuals in crisis,
  - connecting them to appropriate care, and
  - avoiding unnecessary hospitalizations or arrests.

Problem Statement

- **Rising demand for behavioral health crisis care** driven by increased suicidality, substance use, and unmet needs—particularly among vulnerable and underserved populations.
- **Overreliance on emergency departments and law enforcement** for behavioral health emergencies, leading to poor outcomes, high costs, and avoidable criminal justice involvement.
- **Fragmented and inconsistent crisis service availability** across counties, resulting in inequitable access, variable response times, and gaps in care coordination and follow-up.
- **Unsustainable funding and workforce challenges**, limiting providers' ability to staff and operate 24/7 mobile crisis teams under current reimbursement and staffing models.
- **Lack of statewide standards, definitions, and performance expectations** for mobile crisis services, preventing a cohesive, accountable, and scalable crisis response system.
- **Receiving/stabilization centers are a critical and growing service** but fall short of their intent when police remain the default for transport.

Source: Policy Landscape Analysis: Adult Mobile Crisis Services, Clear Pathways, June 30, 2025.

Effectiveness Research

Though **research is limited**, services show promising levels of effectiveness.

Reduced reliance on emergency departments and inpatient hospitalization	**Mobile crisis supports justice-system diversion, decreasing police involvement, and offering safer, community-based crisis responses**	**Clients benefit from effective de-escalation and improved linkage to ongoing care**	**Stakeholder satisfaction is generally high, including among service users, providers, and law enforcement**

Systemwide gaps persist, including *inconsistent implementation, incomplete metrics tracking, and workforce and integration challenges that limit scalability and performance*

Source: Clear Pathways APM Evaluation: Literature Review on Relevant Outcomes and Quality Indicators, Mathematica, August 2025.

Benefits of Participation

Solidify a more rational approach for creating behavioral health regulatory and payment policies

AMC Providers	ADAMH Boards	Ohio Medicaid Managed Care Organizations
• Offers standardized data collection and reporting • Provides clear operational expectations • Supports provider capacity building • Presents an opportunity to inform future policy and program decisions	• Optimizes Medicaid; preserving local resources • Creates a collaborative space to share and receive data that matters	• Tests solutions to reduce ED & inpatient utilization for BH • Helps improve follow-up performance (FUH/FUM/FUI) • Makes “invisible” crisis and follow-up services visible to health plans

APM Phase I & II Highlights

Clear Pathways Mobile Crisis Project

Three-Phase Approach

Phase I

Best Practices Assessment

Completed

Phase II

Expense and Revenue Analysis

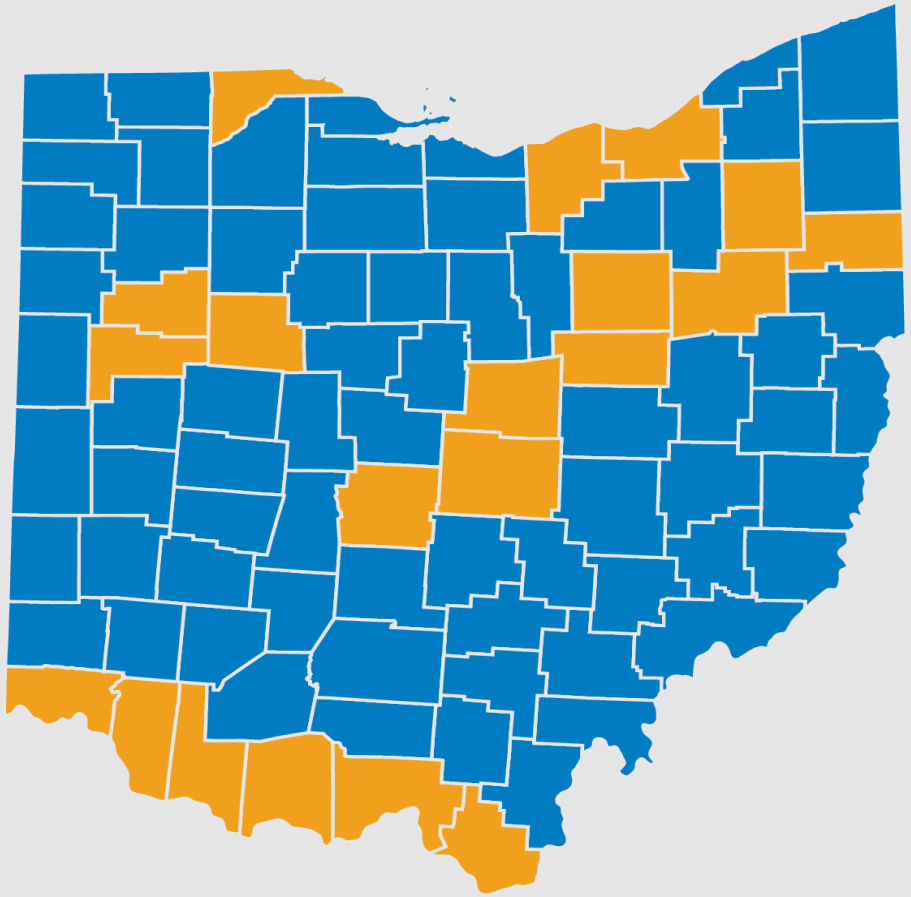
Completed

Phase III

Alternative Payment Model (APM) Demo Implementation

Starts Summer 2026

Participating Providers*



Provider	County/Service Area
Riveon	Lorain County
Zepf Center	Lucas County
Behavioral Health Partners (BHP)	Licking & Knox Counties
Shawnee	Adams, Lawrence, and Scioto Counties
Netcare	Franklin County
FrontLine	Cuyahoga County
Child Focus	Clermont & Brown Counties
UC Health	Hamilton County
Coleman Health Services	Allen, Auglaize, Hardin Counties
Coleman Health Services	Stark County
Coleman Health Services	Portage County
The Counseling Center	Wayne & Holmes Counties

*Phase I included FirstCALL (Cuyahoga County, Shaker Heights)

Phase I – Key Findings at a Glance

Funding is the single greatest barrier to system stability.

All 12 providers described financial strain as a major obstacle.

About half of providers bill Medicaid for at least some crisis encounters.

All 7 providers billing Medicaid reported that reimbursement is low and partial, minimal compared to overall operating costs.

Staffing shortages are a common issue with providers, reporting a shortage of independently licensed clinicians, high turnover, burnout, and difficulty covering nights/weekends.

Nearly every provider cited difficulty recruiting and retaining qualified crisis staff, especially independently-licensed clinicians willing to do field-based, after-hours work.

Phase II – Expense & Revenue Analysis

- **Provider information**
  - Organization details, reporting period, and contextual notes for the adult mobile crisis program.
- **Staffing and roles**
  - Team composition, functions performed across crisis activities, percent of time by role, and Ohio licensure levels (including vacancies).
- **Personnel costs**
  - Wages, benefits, FTEs, PTO/training adjustments, turnover assumptions, and other staff-related expenses.
- **Non-personnel costs**
  - Expenses associated with office, vehicle, medical, client support, information technology, and others (e.g., liability insurance, legal).
- **Utilization and revenue**
  - Service volumes by type and unit, individuals served, and funding sources, including reimbursements, grants, and other revenue.

Phase II – Key Findings At a Glance

Most providers operate adult mobile crisis services at a financial loss, with 83% (10 of 12) reporting a deficit.

Combined net loss of $2.6 million across all Phase II providers delivering adult mobile crisis services.

Adult mobile crisis programs rely heavily on ADAMH Boards as their primary funding source.

Medicaid reimbursements cover a very small portion of expenses, averaging only 6.2%, with no provider exceeding 17%.

Average wages for both clinical and non-clinical roles create recruitment and retention challenges, especially given competition from other sectors with higher pay and fewer requirements.

Units of Measure Vary by Provider and Service Component: 12-month service data across call, mobile onsite, and follow-up encounters showed the need for standardized utilization reporting.

Phase III AMC APM Demonstration

Adult Mobile Crisis Alternative Payment Model Demonstration Overview

Clear Pathways

Clear Pathways is an initiative of Peg's Foundation, the largest philanthropic mental health funder in Ohio. We assist local, state, and national partners with accelerating the implementation of best-practice crisis response. This will reduce the reliance on jails and hospitals, ensuring adults in behavioral health crises have a clear path to getting person-centered help.

Clear Pathways is focused on two critical gaps in Ohio's crisis response system: achieving 911/988 interoperability and **securing sustainable funding for adult mobile crisis services**. This work helps ensure people experiencing a behavioral health crisis can access appropriate, person-centered care in the least restrictive setting possible.

The Demonstration

The Clear Pathways Adult Mobile Crisis (AMC) Alternative Payment Model (APM) Demonstration aims to evaluate new payment approaches with select Ohio adult mobile crisis providers to determine whether implementing a **value-based payment (VBP) model tied to a newly established program standard can improve financial sustainability and AMC quality.**

Key Activities

- Build provider readiness and shared understanding
- Establish baseline data and reporting metrics
- Design and test new APM models that support VBP
- Create tools for learning and improvement
- Evaluate and inform statewide policy

Timeline

Preparation: Launch and Readiness

- Finalize program standards
- Recruit and commit providers
- Complete readiness assessments

Year 1: Baseline and Capacity Building

- Complete initial data collection period
- Deliver APM/VBP boot camp
- Implement standardized reporting

Year 2: Initial APM Implementation

- Develop initial APM
- Apply initial APM with providers
- Launch data visualization tool

Year 3: Refined APM and Policy Guidance

- Refine APM
- Develop recommendations for statewide financing and policy

Benefits

- Optimize insurance coverage and reimbursement to diversify provider payer mix
- Reduce avoidable hospitalizations and criminal legal system involvement
- Improve follow-up and connection to ongoing care
- Prepare providers for VBP arrangements with payers
- Standardize data and improve staffing and response models

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AMC APM Demonstration

Preparation and Year 1

Program Standards & Core Measures

Draft Completed

Provider Readiness Self-Assessment

Draft Completed

APM VBP Bootcamp /Initial Data Collection & Reporting

July 2026

Program Standards

Drafted by Clear Pathways

Establish Clear Expectations for AMC Service Delivery

Gaps in Knowledge

- Conducted a 20-state gap analysis of national data, health plan engagement, and system alignment to understand existing AMC/crisis benefits
- Synthesized insights from CMS, Phase I & II findings, and Ohio-specific lessons learned

Standard Framework

- Created a clear, actionable framework defining foundational policy elements
  - Screening and triage
  - Immediate onsite response
  - Non-immediate follow-up
  - Coordination, referral, and linkages
  - Team composition and competencies
  - Core measures

Outputs

- Fidelity monitoring frameworks to support assessment of APM performance
- Predictability and stability in program financing
- An operational model that can inform future policy and program decisions

Draft Core Measures

Response timeliness (urban/rural)	**Safety plan completion**	Emergency department/inpatient use after AMC
Geographic coverage	**Follow-up within 72 hours**	Outpatient follow-up (7/30 days)
Community stabilization (on-scene resolution)	Warm hand-offs (≤7 days)	Consumer/family experience
Law enforcement involvement	Repeat crisis episodes (30/180 days)	Cost & payer mix sustainability

Providers Self-Evaluate Readiness to Participate in the Demonstration

- High-level checklist to self-assess readiness for implementing AMC services in alignment with the draft Program Standards and other demonstration requirements
- Maximize participation of current providers, and set standards for future provider participation

- Key domains:
  - Operational
  - Clinical
  - Administrative
  - Data and Fidelity
- Implementation readiness indicated by:
  - Yes
  - No
  - In Progress

Provider Readiness Self-Assessment

Assessment domains include:

- **Operational**
  - 24/7 service availability
  - Response time expectations
  - Mobile and telehealth capabilities
  - Community partnerships
- **Administrative**
  - Certifications, policies & procedures, and leadership commitment
- **Clinical**
  - Multidisciplinary staffing
  - Crisis competencies
  - Cultural responsiveness
  - Trauma-informed care
  - Co-occurring capable
- **Data & Fidelity**
  - Systems to capture key performance metrics
  - Continuous quality improvement processes

Demo Year 1: Baseline and Capacity Building

Establishing a strong data and operational foundation

Goals

- Optimize Medicaid payments
- Establish a baseline dataset
- Standardize provider reporting

Activities

- Collaborate to develop a profile of AMC service users and comparison population (e.g., hospital ED/IP visits, readmissions, use of other community BH services)
- Providers submit Medicaid and non-Medicaid claims and begin reporting core measures
- ADAMH Boards maintain current funding levels
- Providers participate in APM/VBP Bootcamp

APM Demo Project Overview

Project Phase	Key Activity	CY Timeframe	Goal
Pre-Socialization	• Present demo concept, capture structured feedback, and align on scope, risks, and decision points. Produce a feedback log and summary.	Q1	Obtain Stakeholder Feedback; Refine Demo
Socialization	• Meeting with Key Stakeholders to share the refined demo, gather feedback on feasibility and data readiness, and confirm engagement model.	Q1	
Recruitment	• CP exploration with stakeholders – evaluation of site commitment, etc.	Q2-Q3	Evaluate Provider Level of Interest/ Commitment
Provider Readiness	• Assess organizational readiness for APM demo participation • Use results to guide tailored support for APM and inform the Glidepath.	Q2	Evaluate Site Level Readiness
Onboarding	• Participate in APM demo kick-off, complete MOU/DUA, and begin system/data reporting functionality	Q3	Formalize Site/CP Partnership
APM/ VBP Primer Bootcamp	• Deliver comprehensive APM/VBP training; define additional provider touchpoints (office hours, FAQs, refreshers) and track completion and satisfaction.	Q3-Q4	Comprehensive Provider Training
APM Data Collection	• Begin data submission for reporting period 7/1/26-6/30/27. • Begin analyzing data from year 1.	Q3 2026-Q2 2027	Initial APM

Q&A

Thank You!
Contact Us

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