



CLEAR
PATHWAYS
An Initiative of Peg's Foundation

Understanding Ohio's Adult Mobile Crisis Landscape

Lunch & Learn

June 18, 2026





Agenda

1 Clear Pathways Overview

2 Phase I Review

3 Phase II Review

4 APM Demonstration

5 Q&A/Open Discussion



Clear Pathways Theory of Change

We Focus Our Efforts in Four Areas

By Employing Key Strategies

To Achieve Long-Term Outcomes

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



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.

- 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.

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.



Three Critical Components of an Effective Crisis Continuum



Someone to Call: Services like the 988 Lifeline and other behavioral health hotlines provide immediate, accessible support.



Someone to Respond: Services like Mobile Crisis Teams that deliver rapid, on-site interventions to de-escalate crises and connect individuals to care, as well as Crisis Outreach Teams that provide complementary crisis prevention and postvention



A Safe Place for Help: A wide array of stabilization services for behavioral health crisis and emergencies where people can receive immediate treatment and support as well as services that can aid in crisis prevention and postvention



What Is Adult Mobile Crisis?



June 18, 2026

Clear Pathways

5

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.





Clear Pathways Mobile Crisis Project

Three-Phase Approach

Phase I
Best Practices Interviews

*February 2025-July 2025
Completed*

Phase II
Expense and Revenue Analysis

*June 2025 – Dec 2025
Completed*

Phase III
Alternative Payment Model (APM) Demo Implementation

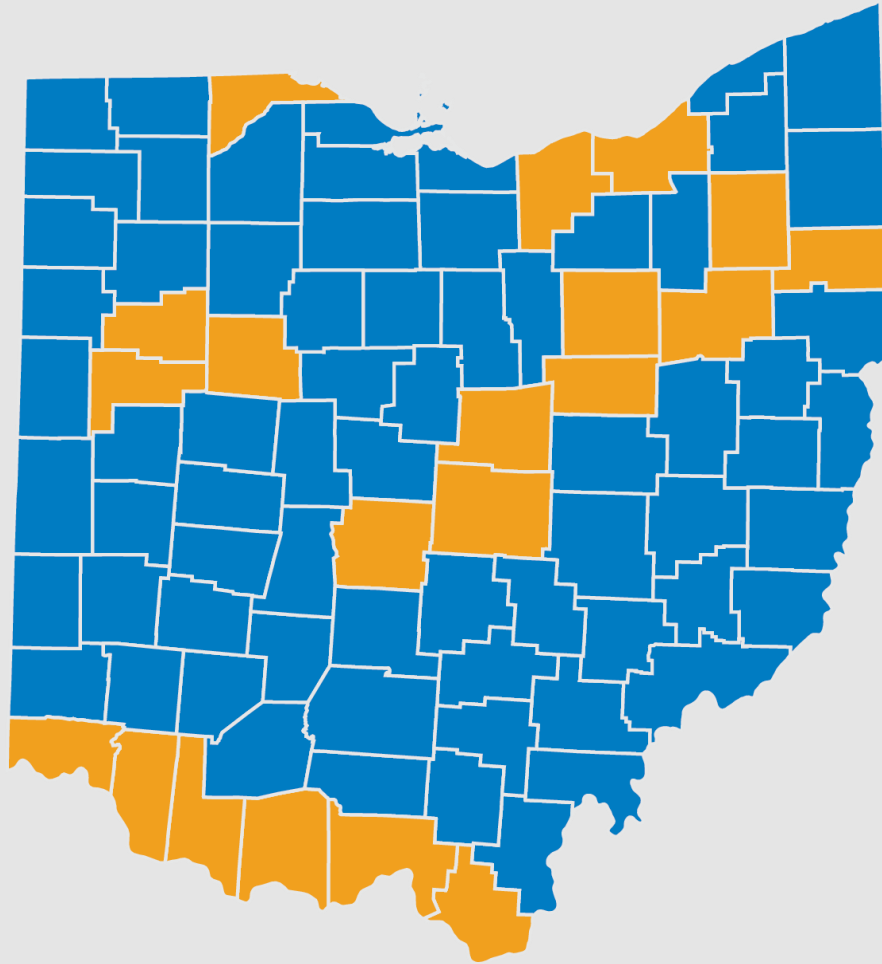
*Prep: Jan 2026 – July 2026
Demo starts Summer 2026*



PHASE I – Best Practice Interviews



Understanding Ohio's Adult Mobile Crisis



Provider	County/Service Area	Population
Riveon	Lorain County	312, 964
Zepf Center	Lucas County	431, 279
Behavioral Health Partners (BHP)	Licking & Knox Counties	241, 240
Shawnee	Adams, Lawrence, and Scioto Counties	159, 725
Netcare	Franklin County	1, 323, 807
FrontLine	Cuyahoga County	1, 264, 817
FirstCALL	Cuyahoga County (Shaker Heights)	(same as above)
Child Focus	Clermont & Brown Counties	252, 277
UC Health	Hamilton County	830, 639
Coleman Health Services	Allen, Auglaize, Hardin Counties	179, 324
Coleman Health Services	Stark County	374, 853
Coleman Health Services	Portage County	161, 791
The Counseling Center	Wayne & Holmes Counties	161, 117



Session Participants

REQUIRED AS APPLICABLE

 Crisis services director or BH provider director


 Licensed BH clinician / clinical supervisor

 Unlicensed behavioral health practitioner

 Peer support specialist or supervisor

 Law enforcement officer (co-responder teams)


 Fire/EMS crisis worker

 Case manager

 Substance use specialist / overdose response

 Crisis line coordinator or call technicians

OPTIONAL / SUGGESTED AS APPLICABLE

 Program funders (e.g., ADAMH Board directors)

 Crisis training coordinator

 Community outreach team members

 911/988 call center directors or supervisors



 Healthcare system rep / hospital-based crisis staff

 Jail-based crisis response staff



Phase I: Best Practice Interviews

What We Asked

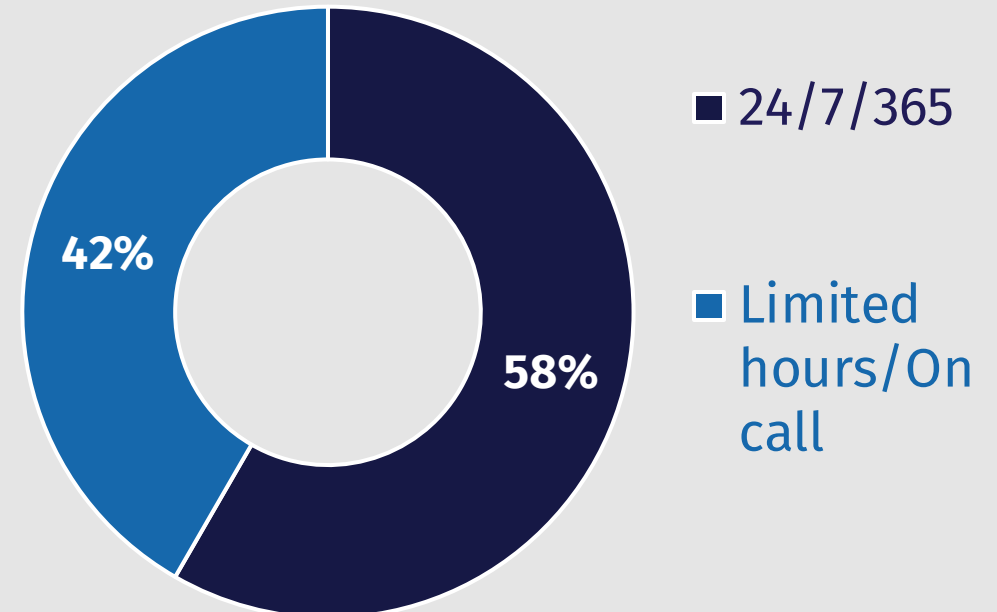
-  Overview of Operations
-  Team Composition and Staffing
-  Initiation and Deployment
-  On-scene Response
-  Follow-up Care and Coordination
-  Community Partnerships and Service Collaboration
-  Technology, Communication, Data Collection & Sharing
-  Funding and Sustainability
-  Challenges and Barriers



Phase I: What We Learned – Operations

- Most providers report operating 24/7 mobile crisis coverage, though a few run extended-hour models (e.g., 8 AM–10 PM) or rely on on-call rotations overnight
- This variation directly impacts response consistency, with 24/7 teams able to dispatch in real time while limited-hour teams depend on call-backs, telehealth, or law enforcement for after-hours coverage

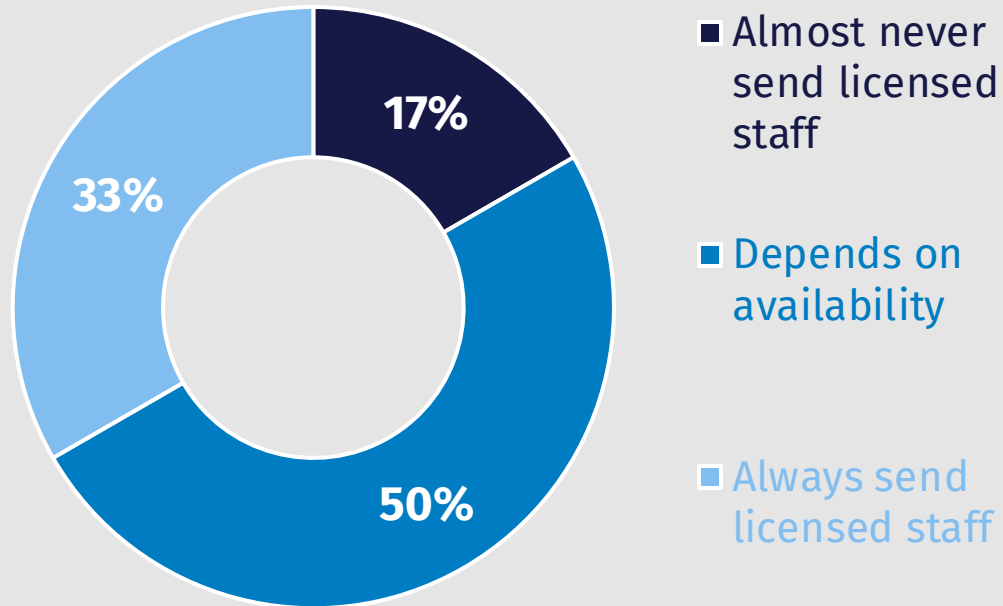
Hours of Operation



Phase I: What We Learned – Staffing



Send Licensed Staff to Calls

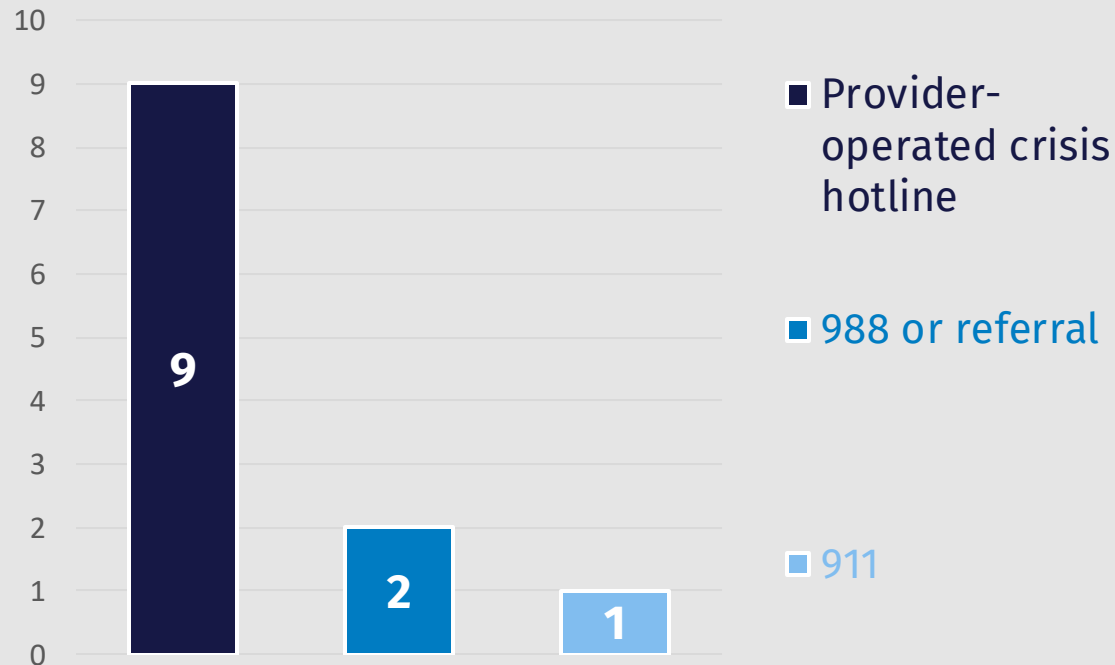


- Most teams stated they try to avoid co-responding with law enforcement unless it is warranted
- **Staffing shortages are a universal barrier:** Nearly every provider cited difficulty recruiting and retaining qualified staff, especially independently-licensed clinicians willing to do field-based, after-hours work



Phase I: What We Learned – Initiation

Call Initiation



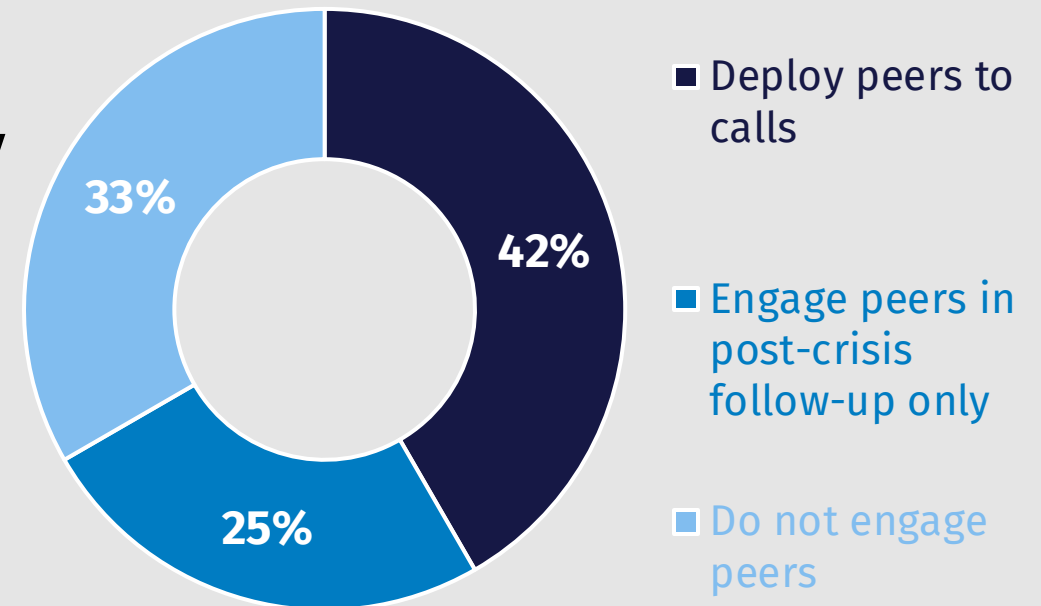
- 92% of interviewed providers dispatch their mobile crisis teams through a behavioral health-led pathway, either from their own crisis hotline or via transfers from 988
- Only one program is fully-embedded in a 911 communications center, where clinicians are dispatched directly alongside police and fire units



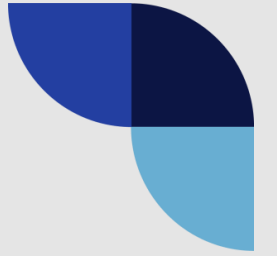
Phase I: What We Learned – Deployment

- The majority of providers aim for two-person teams to respond to calls, typically a licensed clinician with a peer or support staff
 - The reality of this work is that many providers flex between solo and paired response depending on call volume, acuity/risk, and staffing
- Some teams dispatch the same person who is answering the phone, meaning staff are cross-trained to triage calls and respond in person to a crisis

Peer Involvement



Phase I: What We Learned – Follow Up



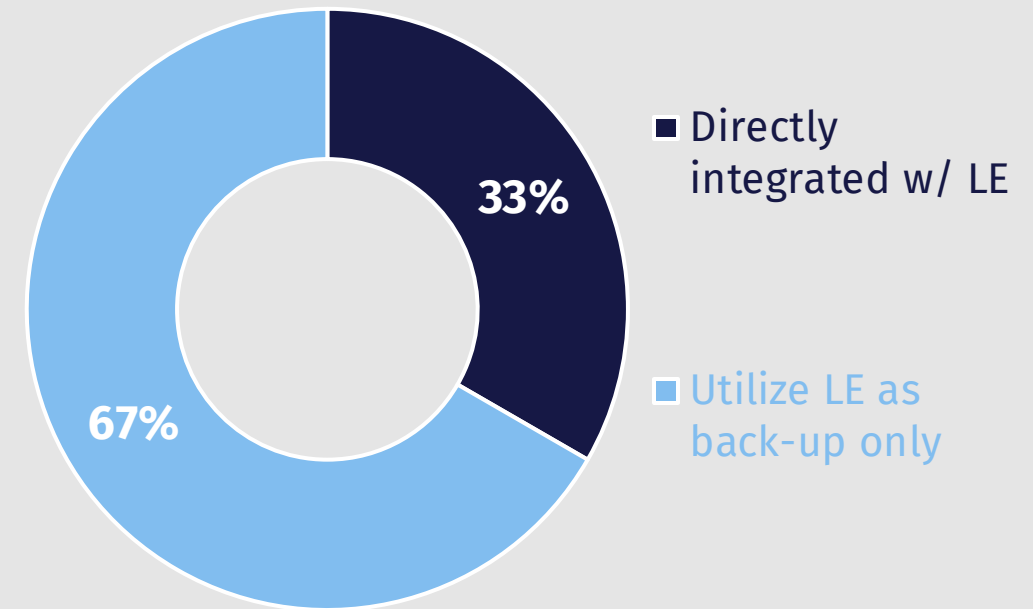
- Most providers aim to follow up within a certain amount of time (up to 7 days) and will check in via phone call or in-person outreach
- Follow up is tailored to the client's situation and needs
- Frequency of follow up dependent on client preferences



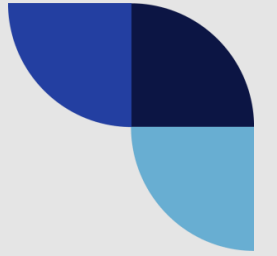
Phase I: What We Learned – Partnerships

- Most providers are trying to reduce default law enforcement involvement
- 58% of providers cite hospital coordination as a persistent challenge
- 42% operate or are directly connected to crisis stabilization/BH urgent care/23-hour observation units
- 2 providers are in the process of building new crisis facilities

Law Enforcement Involvement



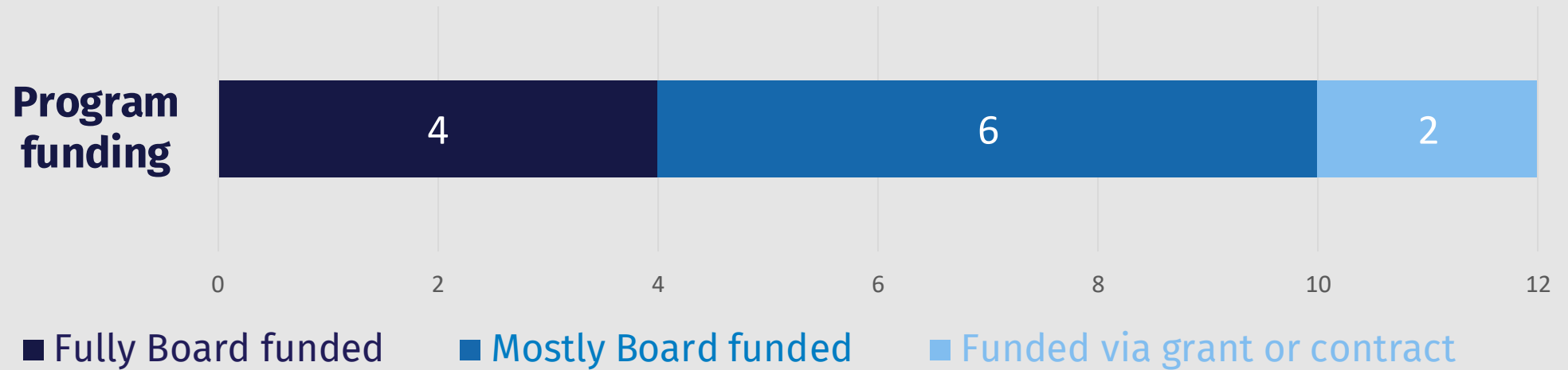
Phase I: What We Learned –Technology, Communication, Data Collection/Sharing



- Most providers track metrics on mobile crisis team operations, whether for internal monitoring, quality improvement, or reporting to funders and state agencies
 - The type and frequency of data collection varies across programs
 - Some providers maintain internal dashboards tracking call volume, response time, and outcomes, while others focus primarily on meeting required reporting metrics
- GPS tracking practices and technology capacity varies greatly across providers
- Providers use different systems for their documentation/electronic health record keeping



Phase I: What We Learned – Funding



- 7 providers bill Medicaid for at least some crisis encounters.
- All 7 reported that reimbursement is low and partial, minimal compared to overall operating costs



Phase I – Key Findings at a Glance

Funding is the single greatest barrier to system stability. All providers described financial strain as a major obstacle.

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.

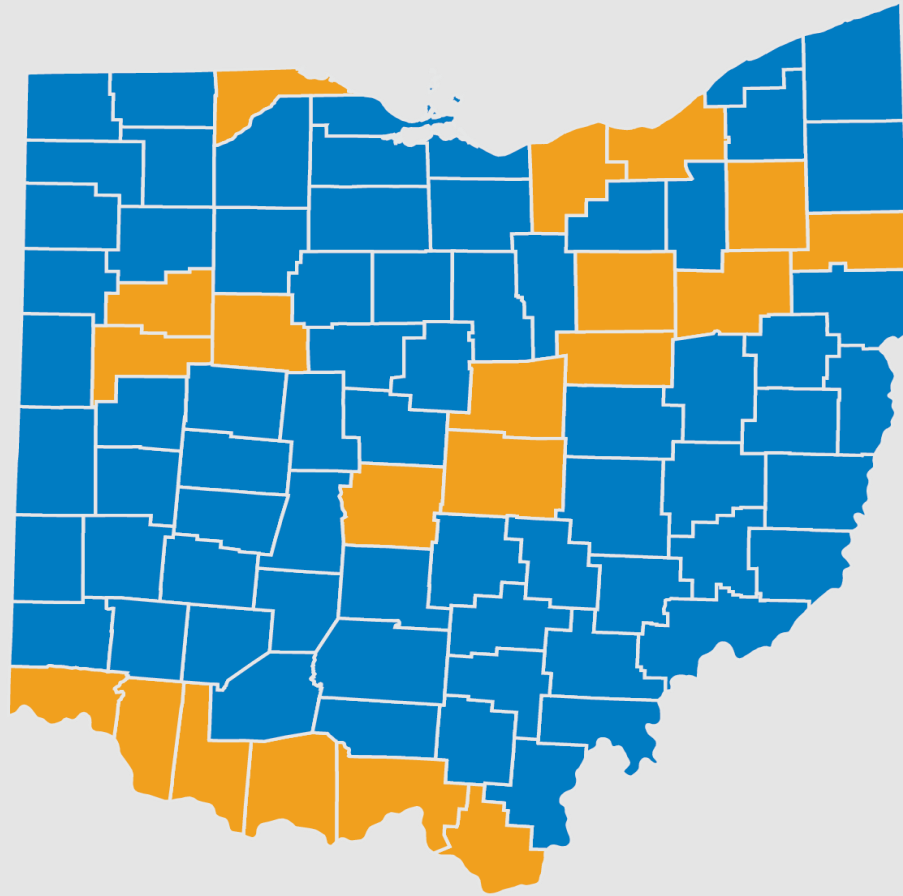


PHASE II – Expense and Revenue Analysis





Phase II 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 II Overview

- Each provider agency received the Expense and Revenue Tool (ERT)
- Each provider agency received instructions and guidance on completing the tool
- Each provider agency participated in a series of meetings to complete the tool
- Clear Pathways provided technical assistance for completion of the tool throughout the process





ERT Overview

- **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 Project Process

PRE-ORIENTATION

- Walk through Phase II documents and timeline
- Introduce Expense and Revenue Tool

ORIENTATION

- Discuss Phase I report highlights
- Review Expense and Revenue Tool instructions and worksheets with financial team

EXPENSE AND REVENUE TOOL REVIEW

- Address provider's questions on completing the Expense and Revenue Tool
- Provide ongoing technical assistance

EXPENSE AND REVENUE TOOL FINALIZATION

- Review submitted Expense and Revenue Tool with provider

CLOSE-OUT SESSION

- Convene all providers to discuss service models and APM options
- Provide an overview of VBP primer





Phase II Key Findings At a Glance

Most providers operate AMC 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 AMC services.

AMC 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%.

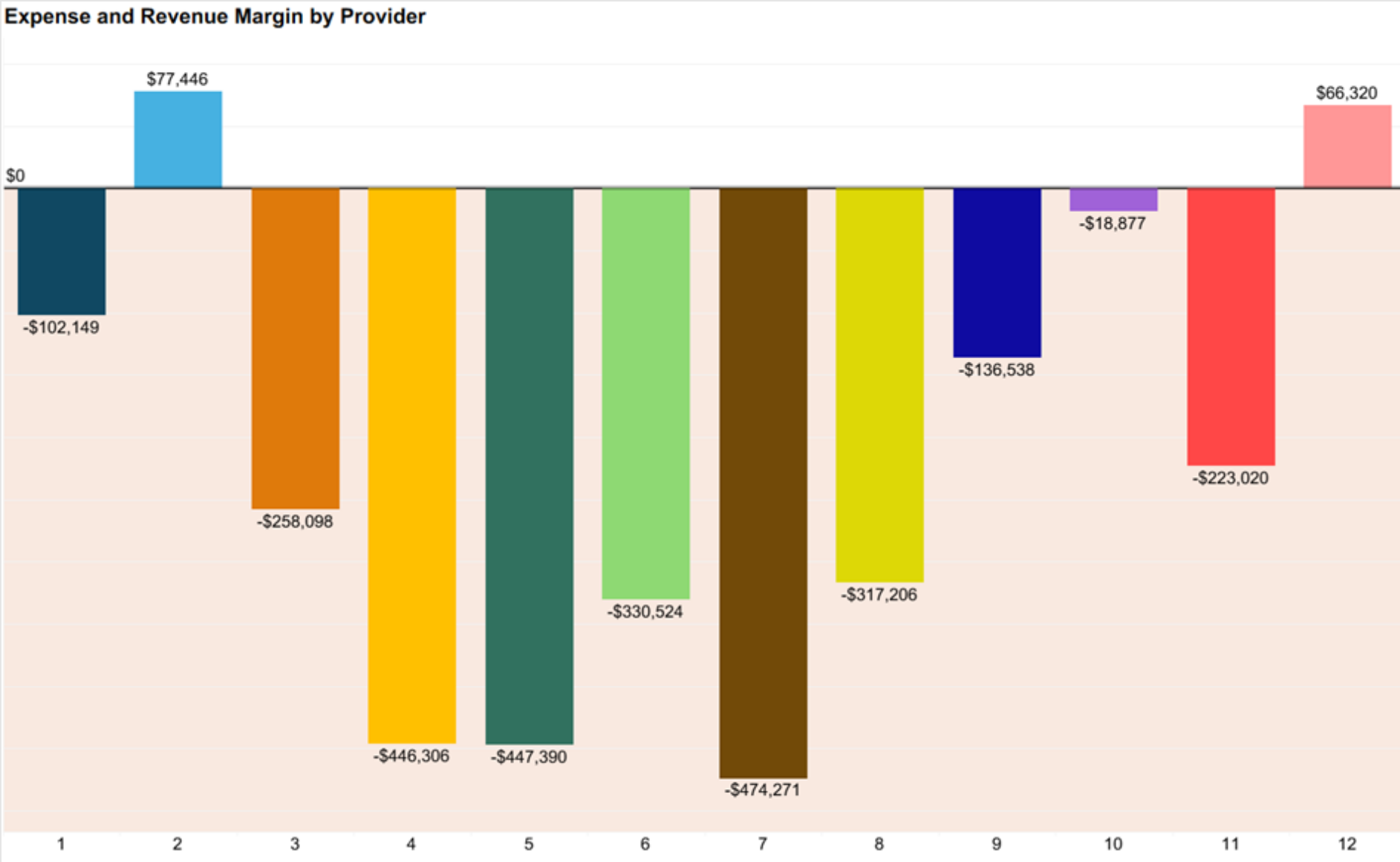
Average wages for both clinical and non-clinical roles create recruitment and retention challenges, especially given competition from other sectors with higher pay and fewer requirements.

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.



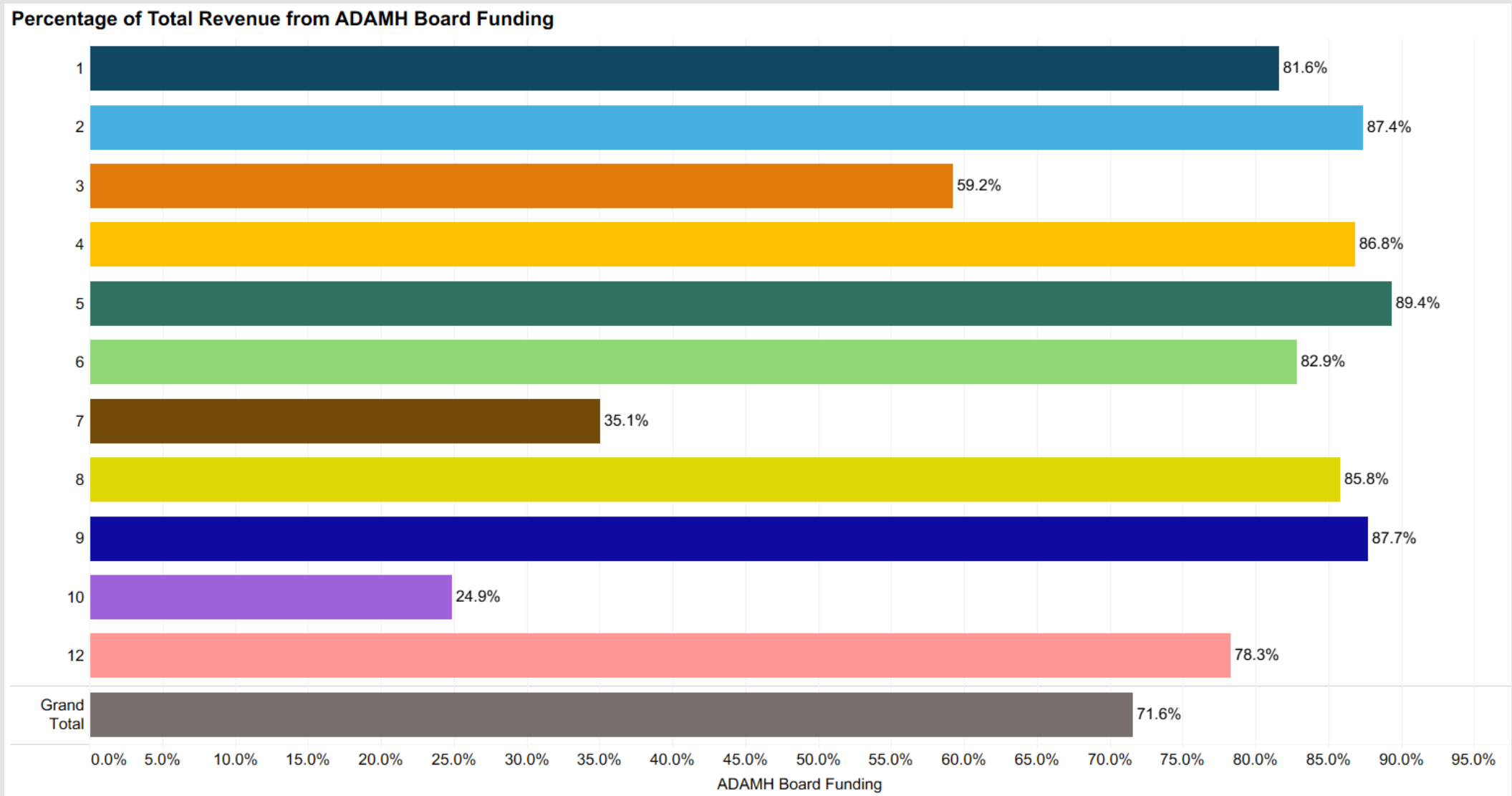


10 of 12 providers reported a loss in the delivery of AMC services.





Of the participating providers, **ADAMH Board funding consisted of 71.6% of all funding for adult mobile crisis programs.**

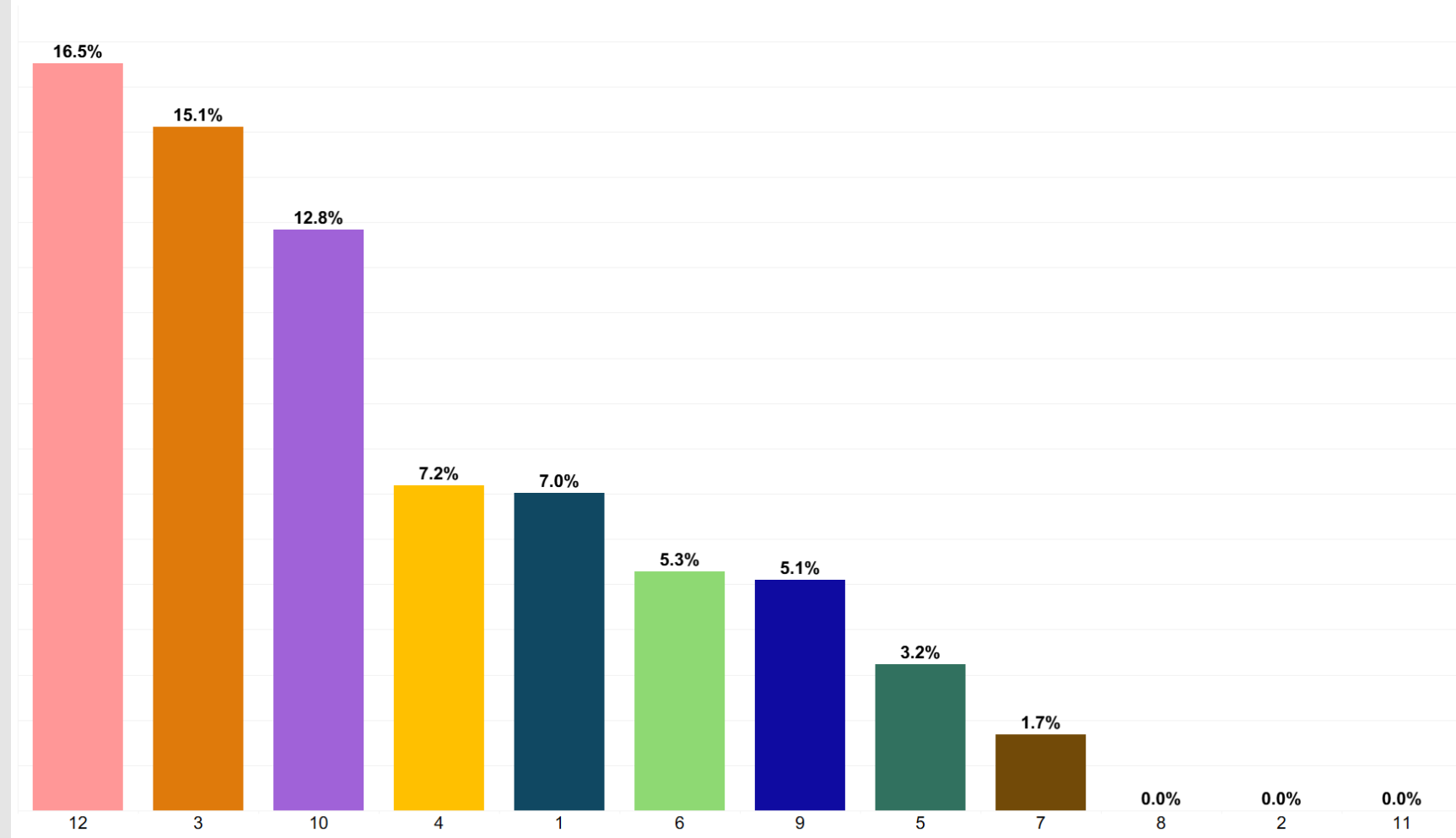




AMC is **not a visible service** under Ohio's current Medicaid benefit structure.

- No provider is receiving Medicaid reimbursements that cover greater than **17%** of all expenses.
- The average percentage of expenses covered by Medicaid for all providers is **6.2%**.
- Many providers reported submitting Medicaid claims and receiving full or partial denials of those claims.
- The number of Medicaid eligible individuals receiving adult mobile crisis services is unknown.

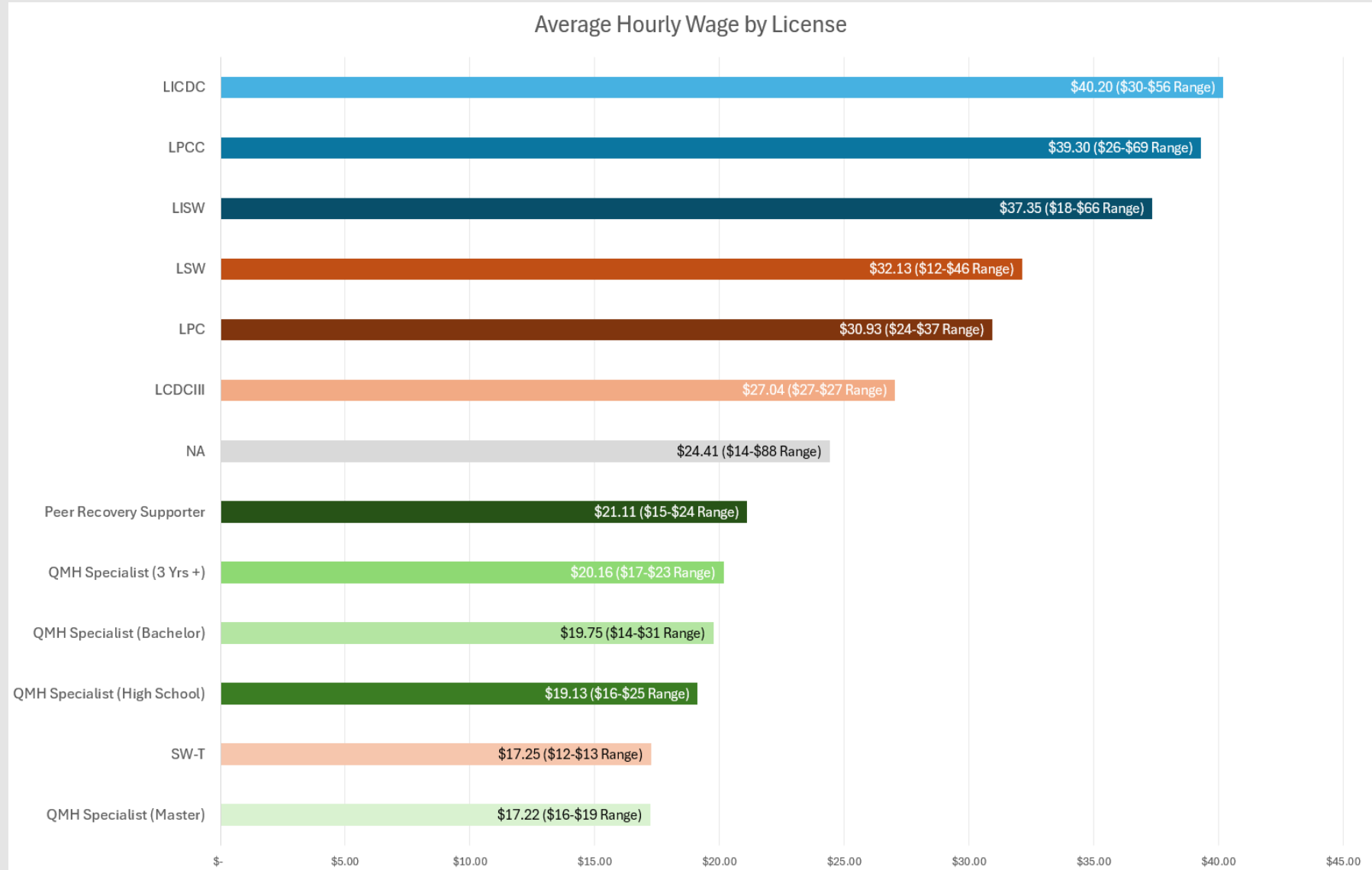
Percentage of Total Expenses Reimbursed through Medicaid by Provider





Independent BH Professionals are making **20% more than BH Professionals under supervision** and **over 90% more than paraprofessionals on average.**

Oranges = BH professionals under supervision
Blues = Independent BH professionals
Greens = Paraprofessionals
Purples = Medical





Key Drivers of Recruitment Challenges

Low Wages for Paraprofessionals

- Paraprofessionals (QMH specialist, peer recovery supporter, etc.) typically make less than the average hourly wage of all Ohio occupations.

High Training Requirements

- Paraprofessional positions require more schooling and certifications than other positions with similar pay.

Intense Competition for Behavioral Health Talent

- Community behavioral health centers compete with other employers that offer similar services with fewer requirements, higher pay, and lower stress.

The average hourly wage across all occupations in Ohio is **\$29.94** per hour.



Additional Phase II Findings

- **81%** of all staff involved in mobile responses are BH professionals under supervision (LPC, LSW, LCDCCIII) and Independent BH professionals (LISW, LPCC, LICDC).
- Personnel costs are **83%** of all expenses for adult mobile crisis providers.
- The average cost of a mobile crisis encounter is approximately **\$400**.
- The impact on the cost of adult mobile crisis services varies by geo-classification with providers in rural counties having a **higher** cost per encounter than urban and mixed counties.
- Providers in rural counties also have a **larger** percentage of expenses not covered by revenue.



Phase III – APM Demonstration Launch



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:
 - Service components
 - Baseline process indicators
 - Quality 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



Establish Clear Expectations for AMC Service Delivery: Draft Standards



Draft Standards Define:

- Screening and triage
- Immediate onsite response
- Follow-up
- Coordination, referral, and linkages
- Team composition and competencies
- Core measures



Insights Drawn From:

- National policy reviews
- State crisis system development recommendations
- Prior project phases and stakeholder engagement
- Feedback directly from providers (ongoing)



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



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 & Capacity Building

- Applying the Standards
- Establishing a Data Foundation
- Providing Technical Assistance and Support
- Building the APM





Audience Poll

Which of the following Value-Based Payment (VBP) Readiness Tools discussed today would your organization be interested in using?

(Select all that apply)

- Best Practice Interview (Phase I)
- Expense and Revenue Tool (Phase II)
- RSA (Phase III)
- None of the above



Questions/Open Discussion



Thank You!
Contact Us



Mobilecrisis@pegsfoundation.org
clearpathwayscollaborative.org

330-655-1366

