Athens-Hocking-Vinton Crisis System Assessment and Recommendations Report

Athens-Hocking-Vinton 317
Alcohol, Drug Addiction and
Mental Health Services Board

April 2024

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

Table of Contents

Executive Summary

In 2023, the Athens-Hocking-Vinton (AHV) Alcohol, Drug Addiction and Mental Health Services (ADAMH) Board, commonly referred to as the 317 Board, contracted with TBD Solutions Inc, (TBDS) to conduct a comprehensive assessment of the region's crisis system and provide recommendations for developing, enhancing, and sustaining behavioral health crisis services.

TBD Solutions engaged a variety of methods, for evaluating the AHV behavioral health crisis system (see figure below).

Overall strengths of the region include: an engaged ADAMH board that convenes stakeholders, gathers data, and solves system challenges; a crisis provider willing to pilot new services to meet the needs of the community, and active agencies responding to crises who actively seek ways to improve the behavioral health crisis system.

Based on the comprehensive assessment of the AHV behavioral health crisis system, TBD Solutions makes the following recommendations:

1. **Convene crisis partners** to identify and implement system-wide solutions **through data-driven decision making**. Offer a shared vision of meaningful, feasible, and actionable data that all agencies engaging in behavioral health crises can gather and present to inform system decisions and improvements.
2. **Enhance the accessibility of community-based crisis care** through strategic combining and co-locating of services as well as alignment with national best practices.
3. **Develop interagency partnerships that enhance the timeliness of care to individuals in crisis** by creating more efficient crisis workflows that maintain reasonable expectations for a limited workforce.

Figure 1. Crisis System Assessment Methods

Introduction

Methods

Results & Analysis

Discussion & Recommendations

Appendix

Introduction

Project Background/Context

House Bill 317 added Alcohol and Drug Addiction Services to the Mental Health boards, creating the ADAMH boards in Ohio to ensure the availability of public mental health and alcohol & drug recovery services. The Athens-Hocking-Vinton Alcohol, Drug Addiction and Mental Health Services Board, more commonly referred to as the 317 Board, is responsible for creating a network of quality care for people who need prevention and treatment for mental illness and/or alcohol and drug addiction in the 1,344 square miles of their three-county catchment area.[1] The 317 Board engages the responsibilities through policy development, program evaluation, securing funds, and service monitoring.

The 317 Board contracted with TBD Solutions, a behavioral health consultancy with expertise in crisis systems of care, to provide an assessment of current crisis services, including identification of strengths and gaps, analysis of available data, identification of opportunities, and recommendations for improvement.

Considerations

Individuals Served

Individuals receiving behavioral health treatment are referred to by many different labels, including patient, client, consumer, resident, guest, individual, and person served. This report is predicated upon recovery-oriented principles in mental health treatment and has elected to use the least stigmatizing language. While TBD Solutions understands the potential breadth and diversity of this report's audience, the language "client" or "individual 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."

Introduction to the Community-Based Crisis System

This report provides an assessment of the community-based crisis system in the AHV region and is designed to give practical recommendations for growth and refinement. A general overview of crisis system design, function, and impact of crisis services is offered to foster a shared understanding of this system.

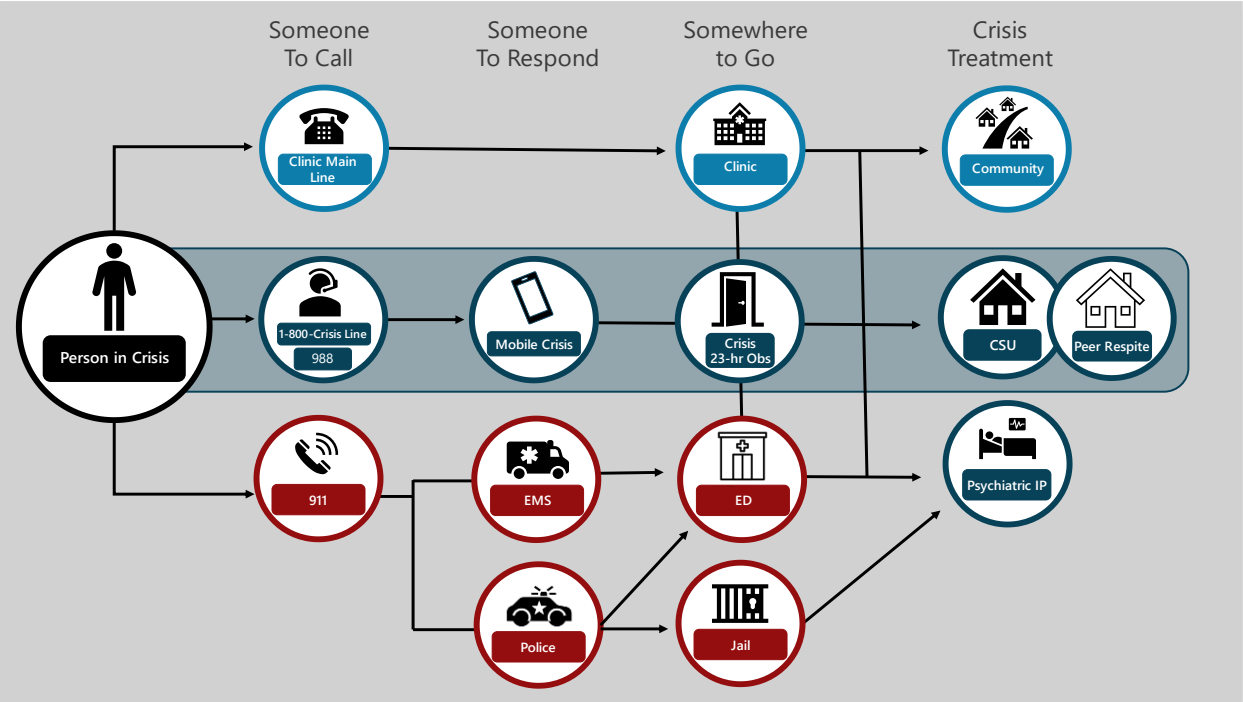
A community-based crisis system is a network of community services designed to provide timely access to evidenced-based treatment for individuals experiencing a behavioral health crisis. While few communities operate crisis systems with services identical to one another, services proven to divert people from non-essential use of emergency departments, law enforcement, or inpatient psychiatric hospitalization include:

[1] Census Bureau Profiles Results

- *Crisis call center*
- *Mobile crisis team*
- *Crisis 23-hour observation*
- *Crisis Stabilization Unit (CSU)*
- *Peer-run respite*

Emergency departments and inpatient psychiatric hospitals also play a role in the crisis system, but the goal for a well-functioning system is to use these services in times of essential need.

Figure 2. The Community-Based Crisis System



Crisis Call Center

Function: To provide 24/7 access to individuals experiencing a behavioral health crisis by a trained counselor who can actively listen, de-escalate, and help resolves crises. For callers needing immediate assistance, call centers complete warm hand-offs to community resources like a mobile crisis team.

Why it Matters: Instead of calling 911 or going to an emergency department, an individual in crisis can access care by talking to someone specifically trained to best meet their needs, often diverting from unnecessary law enforcement and emergency department utilization.

Mobile Crisis

Function: To respond to behavioral health crises in the community as they are occurring, and provide de-escalation, assessment, stabilization, and assistance in resolving the crisis either by intervention or referral.

Why it Matters: When an individual in crisis needs more than a phone call, mobile crisis teams can provide a higher level of care that directly treats a crisis, diverting more individuals from unnecessary law enforcement, emergency department, and psychiatric hospitalization utilization.

Crisis 23-Hour Observation

Function: To create a behavioral health-specific alternative to the emergency department by offering rapid access and intensive treatment for up to 23 hours. Crisis 23-Hour Observation (23-Hour Obs) assists individuals in resolving crises through medication management, peer support, therapeutic interventions, and targeted community referrals.

Why it Matters: Crisis 23-Hour Obs have been found to effectively resolve crises, providing individuals with less restrictive better fit crisis treatment than emergency departments, and faster, less expensive, more accessible treatment than psychiatric hospitals.[2]

Peer Respite

Function: To serve individuals in emotional distress by providing support, counsel, and a welcoming environment to resolve distress and prevent the need for more intensive services. Operated in a community setting, peer respites offer short-term, non-clinical crisis support. People with their own mental health recovery experience staff the home, leveraging their lessons learned to help those going through similar struggles.

Why it Matters: Low barrier access to peer respites have been proven to reduce the utilization of both emergency departments and psychiatric hospitals.[3]

Crisis Stabilization Unit (CSU)/Ohio's Class 1 Residential Facility

Function: To provide a short-term residential alternative to crisis resolution at a psychiatric hospital. CSUs can serve as both a diversion and a stepdown from psychiatric hospitalization by resolving immediate crises, improving overall functioning, and assisting in a smooth transition back to the community. CSU's range in size from 6 to 16 beds, with a length of stay typically between 3 and 10 days.

Why it Matters: Nearly 50 years of research supports the form and function of crisis stabilization units as a viable alternative to inpatient hospitalization. Improvements in clinical outcomes,[4] user

[2] San, D., Kuswanto, C., Sum, M., Chai, S., Sok, H., Xu, C. (2015). The 23-Hour Observation Unit Admissions Within the Emergency Service at a National Tertiary Psychiatric Hospital: Clarifying Clinical Profiles, Outcomes, and Predictors of Subsequent Hospitalization. Primary Care Companion CNS Disorders. 17(4): 10

[3] Croft, B., and Isvan, N. "Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services.". Psychiatric Services, March 2015.

[4] Bola, J. and Mosher, L. "Treatment of Acute Psychosis Without Neuroleptics: Two-Year Outcomes from the Soteria Project. Journal of Nervous and Mental Disease, 2003.

satisfaction,[5] access,[6] and cost savings[7] are all demonstrated through multiple studies, in some cases demonstrating millions of dollars in savings from emergency department and psychiatric hospital diversion.[8]

Inpatient Psychiatric Hospital

Function: To provide the most intensive level of care when needed, serving both voluntary and involuntary individuals. Treatment consists of medication management, various therapeutic offerings, discharge planning and a safe milieu. This treatment is provided by a multi-disciplinary team of prescribers, nurses, clinicians, and technicians during a brief stay.

Why it Matters: Inpatient hospitals provide a critical element of the crisis system by serving those who are acutely in need of close and continuous intervention and monitoring.[9]

The AHV Community-Based Crisis System

Currently serving the AHV region is a crisis call center, mobile crisis team, crisis pre-screening agents, and a dual-program CSU, all operated by Hopewell Health. The dual-program CSU houses both Crisis Respite, a pre-hospitalization stabilization service and the Adam-Amanda Mental Health Rehabilitation Center (Adam-Amanda Center), a post-hospitalization stabilization service.

How to Read This Report

This report presents the AHV Community-based Crisis System Assessment and Recommendations in three parts, see Figure 3 for the breakdown.

Figure 3. Recommendations Report Three-part Breakdown

1. **Methods:** ***What was done to assess the crisis system.*** An overview of the sources of information used for the assessment and how the information was gathered.
2. **Analysis and Results:** ***What was observed about the crisis system.*** The summary and interpretation of the information gathered.
3. **Conclusions and Recommendations:** ***What the analysis and results mean and what next steps could be.*** A discussion of the analyses and presentation of three recommendations based on that discussion.

[5] Adams, C. and El-Mallakh, R. "Patient Outcome After Treatment in a Community-Based Crisis Stabilization Unit." Journal of Behavioral Health Services, July 2009.
[6] Johnson, et al. "In-patient and residential alternatives to standard acute psychiatric wards in England." (2009)
[7] 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.
[8] OImstead, T., et al. "Economic Evaluation of a Crisis Residential Program." Psychiatric Services, March 2022.
[9] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). Roadmap to the Ideal Crisis System: Essential elements, measurable standards and best practices for behavioral health crisis response. Published by the National Council for Mental Wellbeing.

Introduction

Methods

Results & Analysis

Discussion & Recommendations

Appendix

Methods

TBD Solutions assessed the community-based crisis system by interviewing and touring programs of crisis partners and providers in the AHV region and soliciting structured data points pertaining to service volume, outcomes, and quality. Publicly available population data and research on best practices in community-based crisis care supplemented this mixed-methods approach.

Crisis Partner Interviews and Site Tours

Structured interviews with community stakeholders produced valuable qualitative data. From December 2023 through April 2024, TBD Solutions facilitated 40 in-person interviews and 16 virtual interviews and received 11 written survey responses with stakeholders, crisis providers, and individuals served by the crisis system. Interview questions addressed access to care and treatment options, care transitions, community partnerships, service and system performance indicators, peer support utilization, and opportunities for improvement. Interviewees were promised anonymity of their statements to encourage full transparency. TBD Solutions paired several interviews of crisis partners with site tours to better understand the settings of treatment in the AHV region. The full list of agencies interviewed and toured can be found in **Appendix A**.

Figure 4. Community Stakeholder Interview Methods of Assessment

Public and Crisis Partner Data

A data survey offered valuable quantitative data as a component of the mixed-methods assessment. TBD Solutions requested data from each agency substantially engaged in the crisis system.

TBD Solutions gathered the current population, social determinants of health, and health outcomes of Athens, Hocking, and Vinton counties. The list of crisis partners that submitted data and the public databases can be found in **Appendix B.**

Best Practice Literature Review

To better understand a potential future state for the AHV crisis system, TBD Solutions consulted the following national best practice documents:

- *National Guidelines for Behavioral Health Crisis Care*[10]
- *The Roadmap to the Ideal Crisis System*[11]
- *Crisis Residential Best Practice Handbook*[12]
- *988 Report to Congress on 988 Resources*[13]

Limitations

This report's analysis and recommendations should be considered in light of the following methodology limitations.

- **Disparate data submissions.** The crisis data submitted for this report came primarily from Athens County crisis partners, limiting the generalizability of findings to Hocking and Vinton County.

- **Data omissions.** Some requested data is not currently collected or not available. Hopewell Health chose not to share their financial information associated with their crisis services, limiting the awareness of current constraints and opportunities for crisis services.

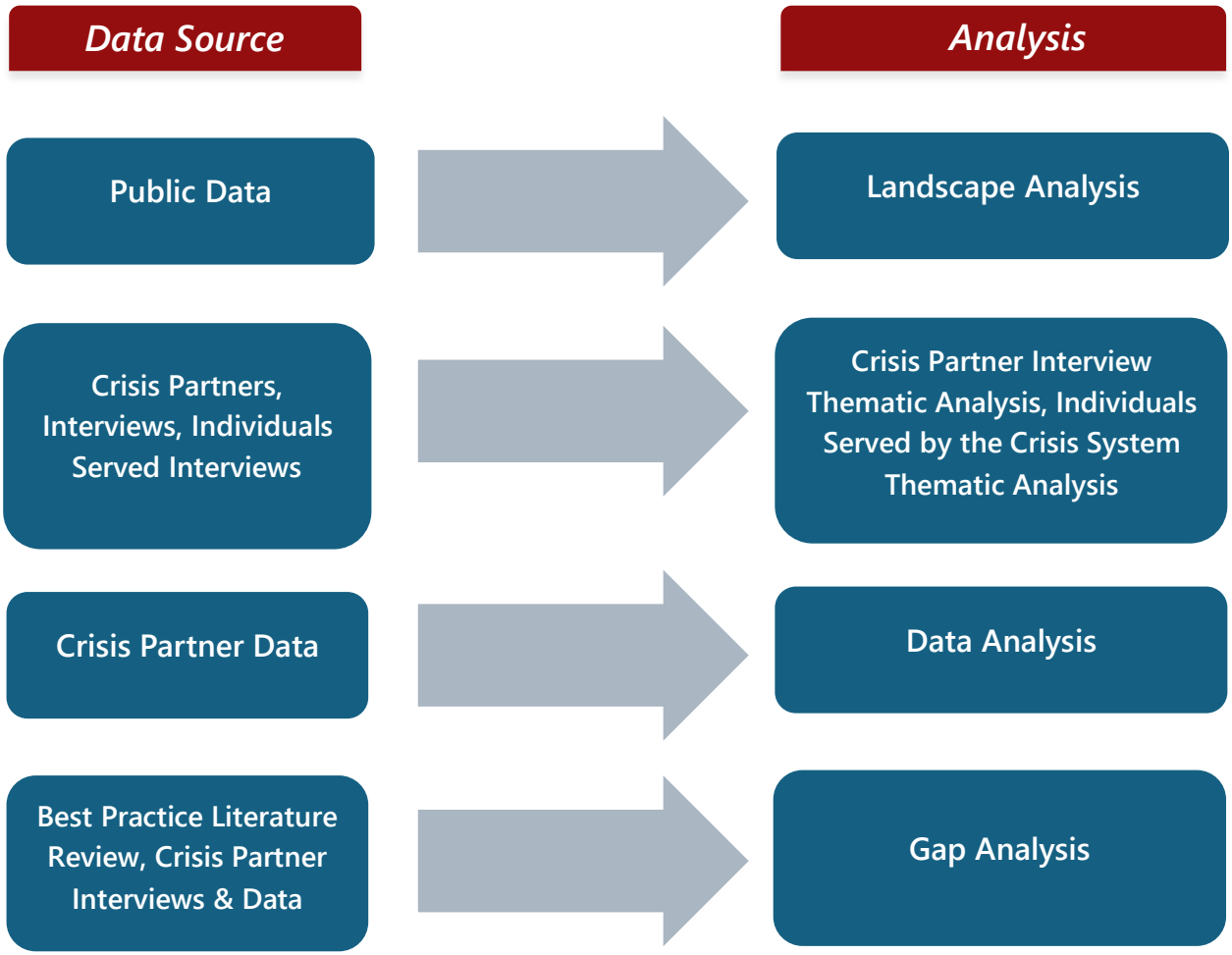
- **Sampling bias.** This report interviewed 22 individuals served by the crisis system and surveyed an additional 11 individuals. All individuals are currently connected to care either with Hopewell Health, Integrated Services for Behavioral Health, and/or The Gathering Place. This group provided helpful insights but is not representative of those who received crisis services and are not connected to ongoing care.

[10] SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit. National Guidelines for Behavioral Health Crisis Care (samhsa.gov).
[11] Committee on Psychiatry & the Community for the Group for the Advancement of Psychiatry. (2021). Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response. Published by the National Council for Wellbeing. 042721_GAP_CrisisReport.pdf (thenationalcouncil.org).
[12] TBD Solutions. (2018). Crisis Residential Best Practices Handbook. Crisis Residential Best Practices Toolkit (crisisnow.com).
[13] SAMHSA. (2021). Report to Congress on 988 Resources. SAMHSA_988 Resources Report to Congress Final.pdf (mhanational.org).

Analytic Methods

Using information from these methods and sources, TBD Solutions conducted four analyses:

Figure 5. Data sources and analysis process



Introduction

Methods

Results & Analysis

Discussion & Recommendations

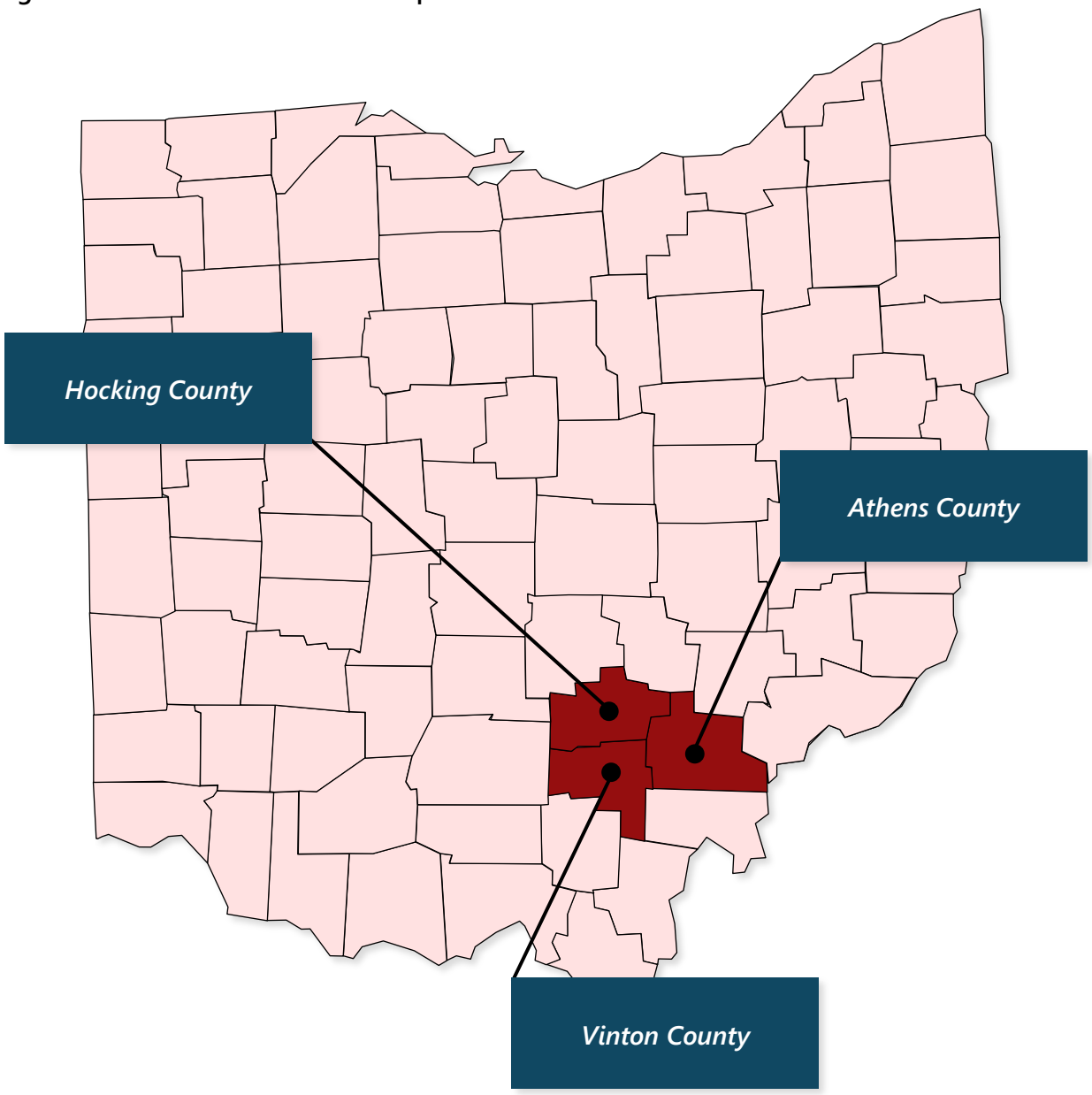
Appendix

Results and Analysis

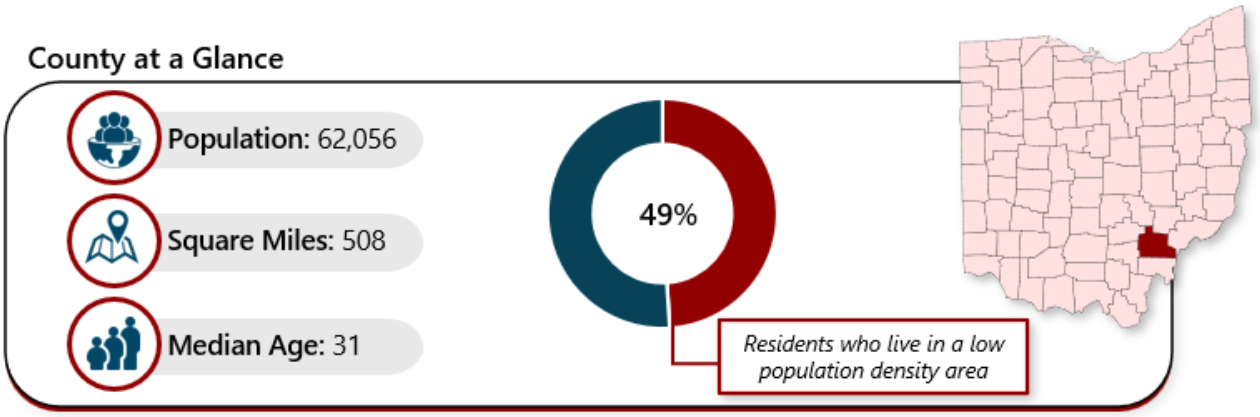
TBD Solutions explored and evaluated the data gathered through four primary methods: a landscape analysis of the AHV population and resources, a thematic interview of the crisis partner and provider interviews, a data analysis of the relative utilization and outcomes of crisis partners, and a gap analysis of the AHV community-based crisis services compared to national best practices.

Landscape Analysis

Figure 6. AHV Counties on Ohio Map



Athens County



County Overview

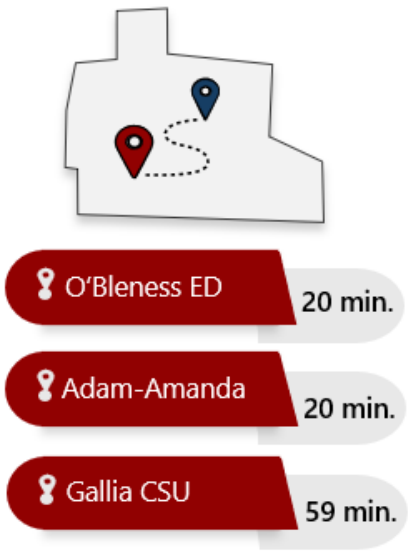
Athens County is the largest county in the AHV region both in square miles and population, with 60% of the region residing here. Bolstered by a third of its population being Ohio University students (Fall 2023 enrollment at the Athens Campus was 21,000), Athens County's median age (31) is significantly lower than the state average of 41.

Ohio University offers easy access to an array of mental health resources and supports. The university population in Athens likely drives several of the above state average social determinants of health and health outcomes. Interestingly, Athens county adult residents do report a higher rate of depressive symptoms.

Athens County is central hub of resources for the AHV region as the home of Appalachian Behavioral Health, Crisis Respite/Adam-Amanda Center, a Mobile Crisis Team, and community support agencies.

Average Travel Time to Services

Across 4 county towns, including the county seat.

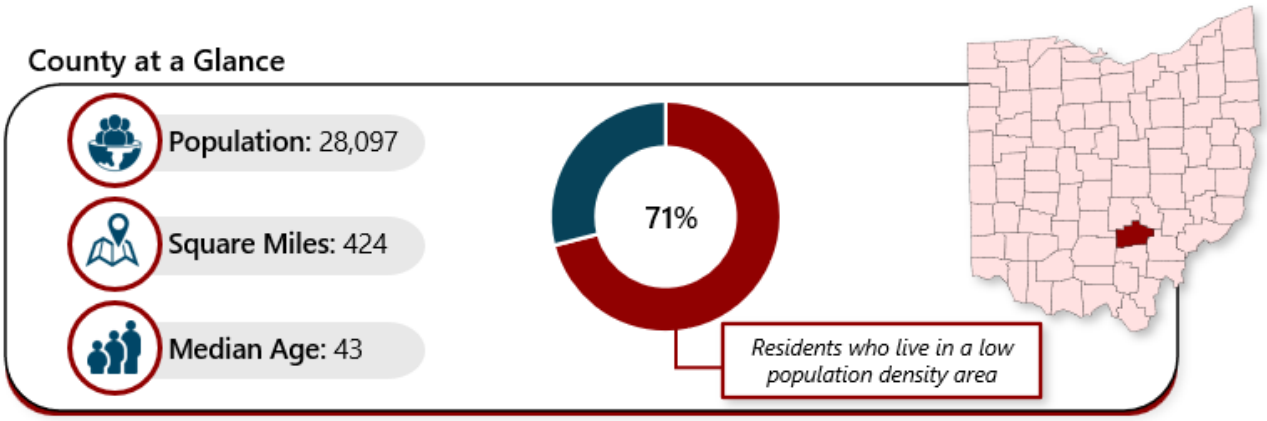


Social Determinants of Health	Athens County	Ohio Avg.	US Avg.
Households Below Poverty Level	**11%**	9%	10%
Residents Who Completed High School	92%	91%	89%
Residents on Public Insurance	**33%**	39%	40%
Ratio of Residents to Mental Health Providers	**150:1**	310:1	320:1

Health Outcomes	Athens County	Ohio Avg.	US Avg.
Adult Residents Reporting Depression Symptoms	**27%**	24%	20%
Suicide Death Rate per 100,000	**11**	14	14
Unintentional Drug Overdose Death Rate per 100,000	**23**	41	-

	What to Build Upon	What to Overcome
Current State	**Strengths** Multiple community crisis specific services active: 988, Mobile Crisis, Crisis Respite/Adam-Amanda Center High utilization of 988 as measured in calls per capita. This is the highest in the AHV region and more than 4x higher than the overall Ohio per capita Better ratio of mental health providers to population than the Ohio and US average (150:1 vs. 310:1 & 320:1) Lower rates of deaths by suicide and deaths by unintentional overdose compared to state and national averages Engaged law enforcement agencies as evidenced by interviews and data sharing	**Weaknesses** Higher rates of depression reported in Athens County compared to Ohio and national averages Current primary way to access crisis care is via law enforcement and the emergency department
Future State	**Opportunities** The 2022 CHNA identified increasing behavioral health care services for mental health and addiction as the top health priority. This offers an opportunity to present solutions for community investment built on this consensus. Create broad access to community-based crisis care with 988, Mobile Crisis, and in Crisis Respite. Connect with engaged partners to problem-solve care coordination challenges and create a more seamless system of care.	**Threats** Poor or unreliable funding for community-based crisis care, particularly mobile crisis, and CSU. This could lead to individuals receiving either the most restrictive and intensive crisis response (emergency department and psychiatric inpatient hospitalization) or no crisis specific response (sent home from a pre-screen).

Hocking County



County Overview

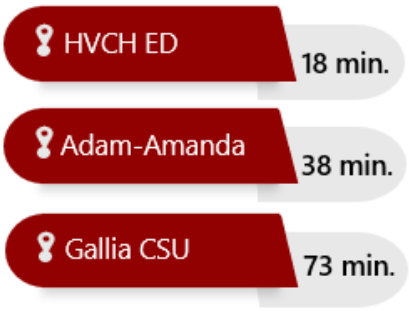
Hocking County is the median county of the AHV region both in size and population. The county is home of the thriving tourist destination of Hocking Hills State Park. With nearly the same square mileage and half of the population, much more of Hocking County is rural and people must travel further to access community resources.

Hocking County is home to a significantly higher rate of individuals on public insurance as well as ratio of residents to mental health providers. In health outcomes, Hocking County deaths by suicide are significantly higher than state and national averages, and the overdose death rate has steadily risen year over year.

The in-county crisis options for individuals in Hocking County is the Hocking Valley Community Hospital Emergency Department, or, if enrolled at Hopewell, their outpatient clinic across the street.

Average Travel Time to Services

Across 4 county towns, including the county seat.



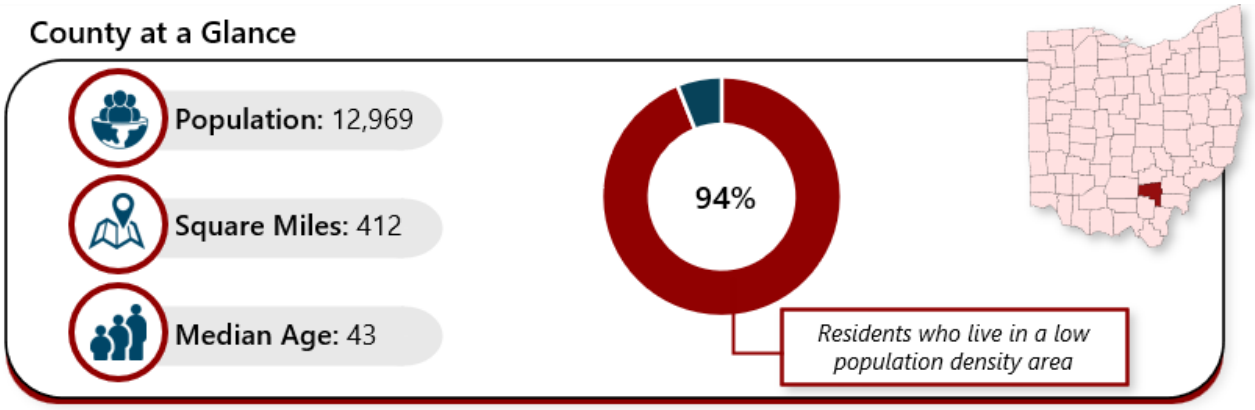
Social Determinants of Health	Hocking County	Ohio Avg.	US Avg.
Households Below Poverty Level	10%	9%	10%
Residents Who Completed High School	88%	91%	89%
Residents on Public Insurance	**48%**	39%	40%
Ratio of Residents to Mental Health Providers	400:1	310:1	320:1

Health Outcomes	Hocking County	Ohio Avg.	US Avg.
Adult Residents Reporting Depression Symptoms	25%	24%	20%
Suicide Death Rate per 100,000	**20**	14	14
Unintentional Drug Overdose Death Rate per 100,000	38.6	41	-

	What to Build Upon	What to Overcome
Current State	**Strengths** Multiple community crisis specific services active: 988, MRSS, Crisis Respite/Adam-Amanda Center Economic growth from growing tourism, with Hocking Hills creating more local financial resources Community partnership evidenced by Mental Health Deputies placed at Hocking Valley Community Hospital Community initiative evidenced by the Appalachian Children's Coalition organizing a youth mental health summit on suicide prevention in Oct. 2023 in response to challenges in that school district	**Weaknesses** Higher rates of SDoH challenges compared to Ohio and national averages, specifically: disability, public insurance, and high school completion rates Higher rates of death by suicide, and in 2023 higher deaths by unintentional overdose compared to state averages. Hocking County had the 12th highest county rate of overdose death in 2023. Crisis access point is primarily the emergency department
Future State	**Opportunities** The 2021 CHIP listed Mental Health and Substance Use Disorders as a priority issue, with particular focus on increasing access to mental health and substance use disorder care. This consensus offers an opportunity to present solutions for the community to investment in. Learn from CHIP Objective 3.2.1 that conducted an assessment to understand why behavioral health workforce capacity is low. Increase partnership with HVCH ED to provide in-person crisis intervention. Increase utilization of Crisis Respite community-based crisis treatment.	**Threats** Unreliable funding for community-based crisis care, particularly crisis intervention and CSU. This can lead to individuals receiving either the most restrictive and intensive crisis response (emergency department and psychiatric inpatient hospitalization) or no crisis specific response (sent home from a pre-screen).

Vinton County

County at a Glance



County Overview

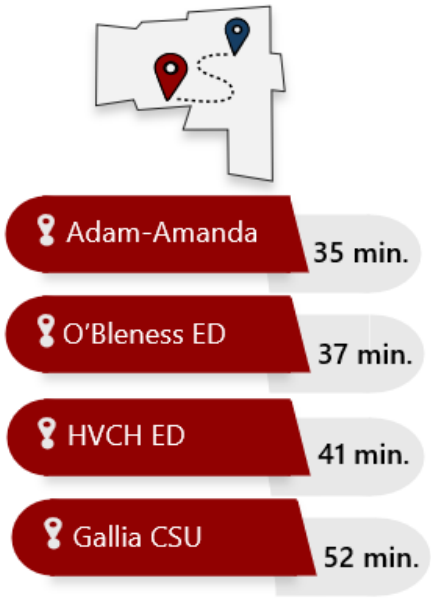
Vinton County is the least populous county in Ohio, with 94% of the county being classified as a low population density area. Accessing crisis resources takes significantly more travel time than the rest of the AHV region.

In line with national trends, the lower population of Vinton County contributes to less economic and social resources, which often correlate with greater social determinants of health challenges. These social determinants of health challenges correspond with poorer health outcomes such as deaths by suicide and drug overdose.

Vinton County residents interviewed during the assessment expressed a resilient, solutions-focused mindset of working finding a way to make things work.

Average Travel Time to Services

Across 4 county towns, including the county seat.



Social Determinants of Health	Vinton County	Ohio Avg.	US Avg.
Households Below Poverty Level	**13%**	9%	10%
Residents Who Completed High School	**80%**	91%	89%
Residents on Public Insurance	**50%**	39%	40%
Ratio of Residents to Mental Health Providers	**790:1**	310:1	320:1

Health Outcomes	Vinton County	Ohio Avg.	US Avg.
Adult Residents Reporting Depression Symptoms	**28%**	24%	20%
Suicide Death Rate per 100,000	**16**	14	14
Unintentional Drug Overdose Death Rate per 100,000	**55.6**	41	-

	What to Build Upon	What to Overcome
Current State	**Strengths** Active community crisis specific services of 988, MRSS, and Crisis Respite/Adam-Amanda Center. Community convening occurring to make system improvements with the overdose fatality review board	**Weaknesses** Higher rates of SDoH challenges compared to Ohio and national averages: households below poverty, high school completion, disability, and public insurance Higher rates of death by suicide, and in 2023 deaths by unintentional overdose compared to state averages– Vinton County had the 2nd highest county rate of overdose death in 2023. Vinton County mental health provider per capita ratio is 790:1 Crisis access point is primarily the emergency department with an average distance to either being 30 miles
Future State	**Opportunities** The 2022 CHNA listed Mental Health and Substance Use Disorders as major health concerns, with a focus on increasing access to mental health and substance use disorder care. This offers an opportunity to present solutions for the community to invest in. The CHNA identified decreasing isolation and decreasing stigma as key ways to improve mental health within the county. The CHNA identified increasing transportation resources to improve access to care. Increase utilization of Crisis Respite community-based crisis treatment	**Threats** Poor or unreliable funding for community-based crisis care, particularly crisis pre-screen/ intervention and CSU. This could lead to individuals receiving either the most restrictive and intensive crisis response (emergency department and psychiatric inpatient hospitalization) or no crisis specific response (sent home from a pre-screen.

Crisis Partners Interview Thematic Analysis

With guidance from the 317 ADAMH Board, TBD Solutions contacted dozens of stakeholders in behavioral health crisis services, including behavioral health providers, law enforcement, private psychiatric hospitals, emergency departments, 988 crisis call center, mobile crisis provider, and individuals with lived experience accessing crisis systems. Fifty-six in-person and virtual structured interviews were conducted. TBDS developed a structured interview guide covering multiple facets of each community's crisis system, including access to care and treatment options, care transitions, community partnerships, service and system performance indicators, peer support utilization, and opportunities for improvement. Interviewees were offered anonymity of their statements to encourage full transparency.

The following four themes emerged from the interviews:

1. Low Utilization of Local Crisis Programs

During the interviews, agencies expressed difficulties accessing and utilizing crisis programs including mobile crisis and Hopewell's Crisis Respite. Several partners shared they attempted to access the mobile crisis team to address a mental health crisis in the community, only to be informed that the team was unavailable. After several attempts to access crisis services, agencies reported either slowing or stopping their attempts due to inconsistent and unreliable access issues.

The mobile crisis team currently operates Monday through Friday from 9am to 5pm and is staffed by a clinician and a paramedic. Hopewell Health reports that the mobile crisis team is at times unavailable because they are responding to another crisis at the Athens Hopewell clinic or transporting an individual to an inpatient unit in Columbus, a 150-mile round trip.

Interviews with Crisis Respite staff revealed that unfamiliarity with the person seeking services, their behavioral and medical acuity, and their ability to fully participate in programming all play a role the individual's ability to meet the respite program admission criteria.

2. Reliance on Law Enforcement and Hospitals

Law enforcement officers emphasized their reliance on emergency departments (ED) as the primary drop-off location for individuals experiencing a mental health crisis. Interviewees suggested that some individuals may visit the emergency department multiple times due to the absence of follow-up care after their ED or inpatient visit. Additionally, individuals released to return home from the ED with a safety plan are sometimes seen by local law enforcement walking on the streets. This recurring scenario caused much frustration among law enforcement interviewees.

Once the individual in crisis arrives at the ED, they undergo a medical clearance process and obtain a crisis pre-screen. Interviewees shared two concerns with the pre-screening process. First, the amount of time an individual waits in the ED before being screened for inpatient services, with mounting frustration at wait times between requesting a pre-screen and the arrival time of the pre-screener. Some interviewees believe the long wait times may be related to workforce shortages. Second, most crisis pre-screens occur via telehealth, limiting the breadth of assessment, intervention, and collaboration. Hopewell currently conducts all crisis pre-screens at Hocking Valley Community Hospital (HVCH) and Southeast Ohio Regional Jail (SEORJ) via telehealth. The wait for this virtual pre-screen may also take hours.

After the crisis pre-screen, if an individual requires psychiatric inpatient care, they must wait for an available hospital bed and corresponding transportation. A private EMS agency provides transportation for the 75-mile trip to Columbus psychiatric hospitals, which reportedly can extend the individuals time in the ED by 6-12 hours.

ED boarding is the practice of holding admitted patients in the ED while they wait for an inpatient bed to become available and poses a significant safety risk. The Joint Commission, an accrediting body for hospital systems, mandated that boarding should not exceed four hours[14], but interviews with local emergency departments revealed that individuals experiencing a mental health crisis regularly wait over four hours. In some cases, individuals have waited as long as 8 to 12 hours. Boarding is especially problematic for Hocking Valley Community Hospital as the ED was designed for 20–25 individuals per day and the current average ranges from 40–60 individuals per day. It was noted that some people have remained in the ED for up to eight days.

Anecdotally, interviews indicated ED medical clearance often does not identify unknown medical problems, and the focus is frequently on monitoring the individual in crisis while they are

Law Enforcement Crisis Response

To illustrate law enforcement's current role of crisis first response, one of the region's law enforcement agencies shared this recent vignette:

[In} February 2024, a law enforcement officer (LEO) responded to a call from a concerned friend of an 18-year old male in crisis with no threats of harm being made to self or others. A LEO arrived on scene and found the male on crutches, by himself, crying uncontrollably, stating that he was suffering from depression largely due to his injury. The LEO listened to the juvenile, validated the juvenile's position, and provided options for follow-up care. The male was receptive and agreed to allow his parents to be contacted. The parents arrived on scene and took custody of the male. Later that night, the LEO received a text from the family, "Not 100% sure what is going to happen next, but we have a lot of resources and referrals. I can never thank you enough. [The youth] is very blessed to have brave friends."

[14] The Joint Commission. R3 report: requirement, rationale, reference. Accessed March 13, 2022. https://www.jointcommission.org/-/media/tjc/documents/ standards/r3-reports/r3_report_issue_4.pdf

intoxicated. Interviews with law enforcement officials indicate a significant number of patients experiencing a mental health crisis are also experiencing drug-induced psychosis.

3. Lack of Clarity of the Crisis System

Interviews with community partners and Hopewell leaders revealed inconsistent communication within the Hopewell organization. An observed example was the type of referrals allowable for the Crisis Respite program. Several Hopewell interviewees reported the crisis respite program accepts community referrals, while others reported not allowing community referrals. Multiple interviewees described the admission criteria as being exceptionally challenging.

The lack of clarity in the crisis care system is partly due to a lack of routine communication between the mobile crisis team, 988, and the crisis respite program. A few people interviewed expressed their desire for a more "seamless" crisis care system. The silos in the system are partially due to the absence of a communication strategy and related protocols between services. Strong community partnerships are needed to assist with diversion from less appropriate settings, to increase awareness of crisis services, and to establish linkages to community services.[15]

4. Workforce Shortages

Fully functioning crisis programs require a team of invested professionals working together to serve people in community-based settings. Workforce shortages create challenges in preventing over-utilization of emergency departments and psychiatric inpatient hospitals for individuals who could safely be served in or by a less restrictive level of care. Mobile crisis, Crisis Respite/Adam-Amanda Center, law enforcement, EMS, emergency departments, and outpatient services all spoke to widespread workforce shortages throughout the community. These shortages create a negative domino effect throughout the community-based crisis system.

If a fully functioning mobile team existed, a reduction in law enforcement involvement in mental health crises would occur. With less law enforcement engagement and more community-based crisis resolution, less individuals in crisis would be taken to an emergency department. Instead, workforce shortages increase response time to community-based crises services, increase wait times for treatment, burden law enforcement to respond to behavioral health emergencies, create a bottleneck that extends boarding in the ED's, and reduce the acuity level that Crisis Respite/Adam-Amanda Center can accept. This cascading avalanche of workforce issues means individuals in crisis receive delayed and diminished access to services when they are needed the most.

[15] Pietras,S., Wishon, A.,(2021) *Crisis Services and the Behavioral Health Workforce Issue Brief* HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy, Crisis Services and the Behavioral Health Workforce Issue Brief | ASPE (hhs.gov)

Crisis System Service Recipients Interviews

In March 2024, TBD Solutions conducted interviews with community members who have accessed crisis services. Participation by service recipients was voluntary and responses included citizens from the following counties: Athens, Hocking, Vinton, Gallia, Jackson, or Meigs county.

1) Empathy drives positive outcomes in crisis situations. Individuals emphasized the importance of personal interactions when resolving crisis situations and how this approach leads to a more positive impact on treatment overall. Having someone who listens, is empathetic, and guides individuals to the correct resources were reported to be the most helpful for individuals experiencing a crisis. Interviewees reported negative experiences when they were talked down to, called names, or addressed in a condescending tone by law enforcement, 988, 911, or workers from Adam-Amanda Center. Interviewees reported feeling dismissed and often felt their crisis worsen. One participant noted that crisis services could improve if equality was prioritized and providers sought to "treat everyone the same."

> ***"My outpatient counselor slowed things down and listened to me. I just didn't want to be alone."***

> ***"My friend came and helped when I posted pictures of me holding a gun to my head. He said he was going to beat me up if I didn't stop, then shared that I was part of the group, and the group loved me."***

2) Service Access Issues. Individuals served reported frustrations with crisis services due to issues with accessibility. Many interviewees self-identified as homeless, describing a lack of temporary housing resources in the area. Two of the most critiqued community-based crisis services were the Adam-Amanda Center and mobile crisis. The Adam-Amanda Center has a reputation for declining people referred from the community, and one participant noted that you "have to know someone to get in." Individuals served believed mobile crisis was a 24/7 option, but those who tried to access mobile outside of the operating hours were either referred to another service or denied services altogether. Organizations such as The Gathering Place and Integrated Services for Behavioral Health received positive feedback and are seen as helpful resources for community members.

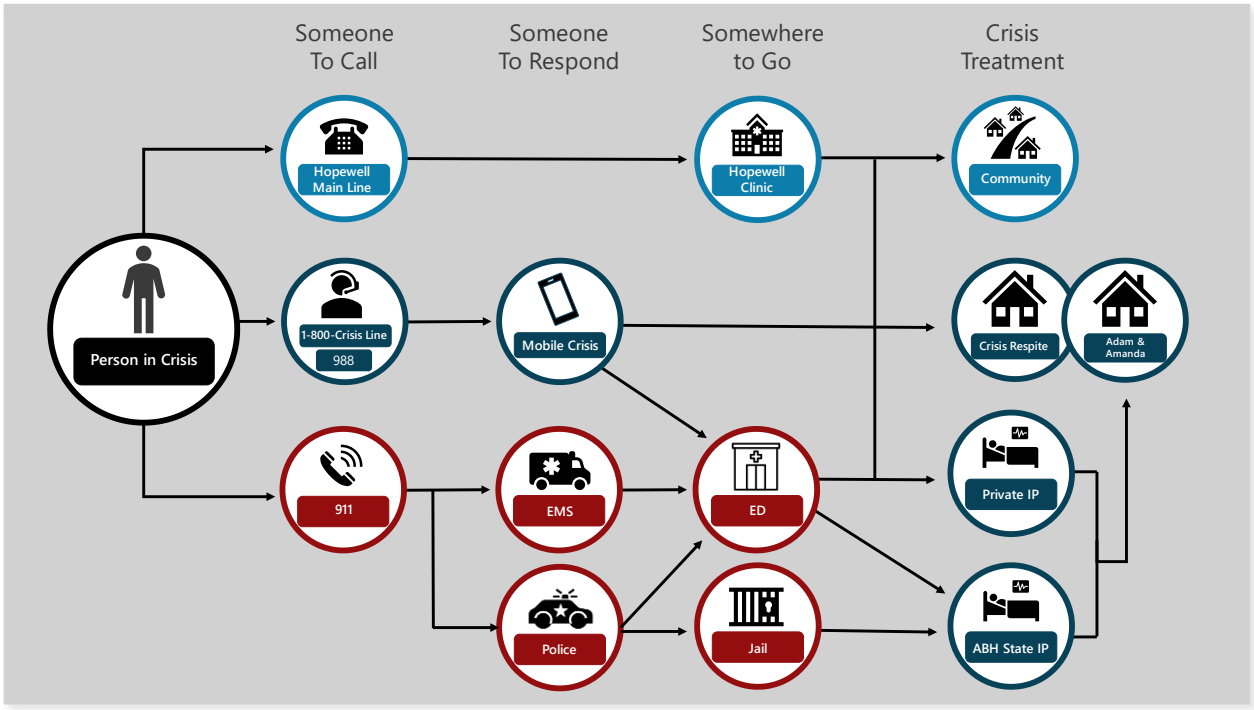
3) More focus on care models and aftercare needed. Individuals served report crisis services can improve by developing recovery-focused treatment plans and having more intentional follow-up care. Participants shared a desire for crisis service providers to slow down, explain options clearly, and provide a sense of safety to those they are serving. Individuals served shared that 1:1 counseling, more frequent check-ins from therapists, and timely access to prescriptions would improve crisis services overall.

> ***"All of my crises have happened at night."***

Crisis Partners Data Analysis: Athens County

Based on crisis partner and provider interviews, the current AHV behavioral health crisis system sets up the following care paths that an individual could experience in a crisis.

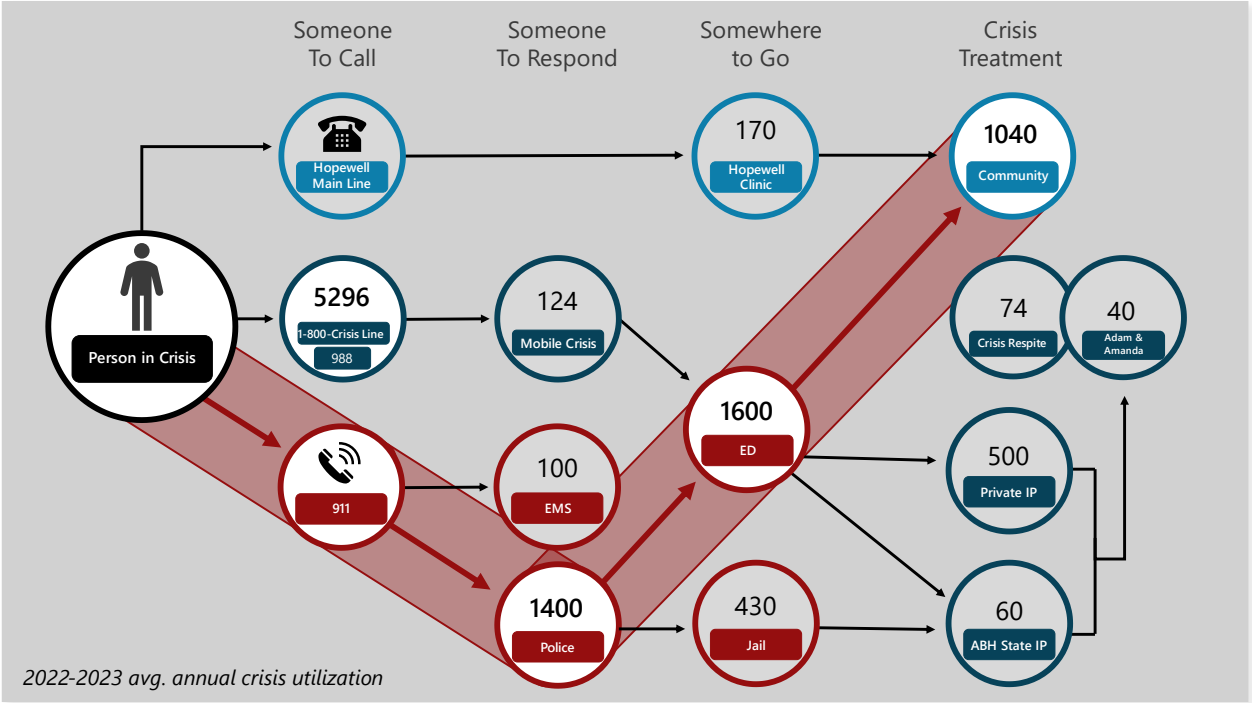
Figure 7. The Current AHV Behavioral Health Crisis System



Athens County stakeholders, Hopewell crisis programs, and the 317 Board shared robust crisis utilization data that supported a picture of the current primary crisis pathway in Athens County to emerge. Figure 7 shows the 2022-2023 annual average utilization of the Athens Crisis System. The specific data sources and definitions can be found in **Appendix B**.

Together, these data reveal the primary pathway of crisis care in Athens County for 2022 and 2023, see Figures 8 & 9.

Figure 8. Current Primary Pathway of Care in the AHV Crisis System



Based on collected data, the most common crisis care pathway in Athens County is to encounter a law enforcement officer as a first responder, go to the emergency department for assessment and stabilization, and then return home with a safety plan to wait for outpatient treatment.

Figure 9. Current Primary Care Pathway

Gap Analysis

Hopewell 988 and Crisis Line

In an ideal community-based crisis system, individuals can engage the crisis system through a crisis call center for assistance 24/7/365. Crisis call centers assist individuals experiencing a behavioral health crisis by establishing rapport and de-escalating the immediate tensions by offering emotional support and linking individuals to appropriate system resources. A community's familiarity with the crisis call center's phone number and function impacts the center's effectiveness. Educating the community to call the center instead of 911 or presenting to the local emergency department will improve the center's service to the community.

Hopewell operates both a 988 and 1-800 Crisis Line, staffed by the same call takers. This team always has at least one call taker online, but typically staffs two at the same time. Call takers are based out of the 317 Board building, or, if a single 988 call taker is working after hours, the Adam-Amanda Center.

Table 1. Crisis Hotline Ideal Features

Crisis Hotline: Ideal Features	
Focus Area	**Current**
Operates 24/7/365.	☑
Accepts all calls, including information and referral inquiries.	☑
Incorporates phone, text, videoconferencing, and web-based chat capability.	
Provides services in other languages and/or translation services are available.	☑
Serves as an initial mode of engagement, de-escalation, triage, and support to the caller.	☑
Accepts and triages calls from 911.	
Is capable of dispatching mobile crisis services.	☑
Connects individuals to facility-based care through warm hand-offs and coordination of transportation as needed.	
Is responsible for tracking data on the type of call, length of call, and outcome of call.	☑
More intensive interventions are engaged for less than 20% of all calls.[16]	☑
Use of measurement-based care for continuous improvement, including tracking and responding to safety, efficacy, and timelines of service outcomes.[17]	
ADDITIONAL FEATURES FOR 988 CENTERS	
Has an active agreement with the administrator of 988 for participation within the network.	☑
Complies with the NSPL requirements and best practice guidelines for operational and clinical standards.	☑

[16] Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies | Psychiatric Services (psychiatryonline.org).
[17] SAMHSA_988 Resources Report to Congress Final.pdf (mhanational.org).

Crisis Hotline: Ideal Features	
Focus Area	**Current**
Shall meet the requirements set forth by the National Suicide Prevention Lifeline for serving high-risk and specialized populations, including individuals with co-occurring mental health and substance use disorders and other relevant and culturally sensitive special populations, as identified by the federal Substance Abuse and Mental Health Services Administration, including training requirements and policies for transferring callers to an appropriate specialized center or subnetwork.	☑
Provides follow-up services to individuals accessing the 988 crisis hotline consistent with guidelines and policies established by the National Suicide Prevention Lifeline.	☑

Significant Data Points

From calendar year 2022 to calendar year 2023, the crisis call center saw a **25% increase** in calls received from **4,556 to 6,037** (see Figure 10).

To consider 988 awareness and utilization, this report synthesized a per-capita-calls rate by pairing the population of each county by number of calls received from that county, and then applied the metric to Ohio statewide data. This analysis revealed a wide range of calls per capita across Athens, Hocking, and Vinton counties.

Figure 10. Crisis Call Center Received Calls

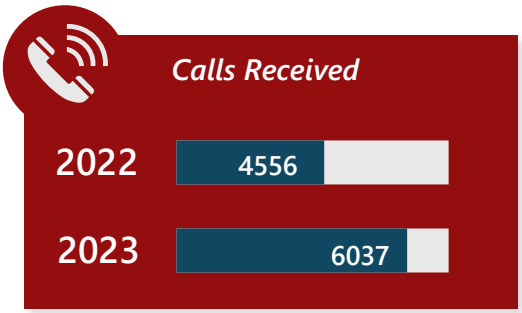


Table 2. Number of County Residents per 988 Call in 2023

Athens	23:1
Hocking	63:1
Vinton	141:1
Ohio[18]	107:1

In 2022 and 2023, **Hopewell 988 averaged utilizing more intensive interventions on 8% of calls** in the Athens, Hocking, and Vinton area significantly better than the recommended 20%. More intensive interventions are referrals to a higher level of care such as mobile crisis, an emergency department, or law enforcement.

[18] Ohio population of 11,760,000 **/ (**9,115 calls per month x 12 months) = 107:1

Identified Gaps

- In October of 2022, leadership from 911 and 988 met and identified the utility of creating a conditional referral pathway from 911 to 988. As of the writing of this report, this referral pathway planning has not occurred. Commonly, 911 centers adopt the stance that if an individual calls 911, that means the individual is an emergency and it is 911's duty to respond. However, several 911 centers are moving towards a collaborative or integrated system approach such as in Polk County, Iowa; Harris County, Texas; and Davidson County, Tennessee.
- The 988 Call Center will directly refer individuals through a warm handoff to Hopewell's outpatient services but will otherwise refer individuals to other services such as the emergency department.
- In current outcome data tracking, functionality is missing to track call abandonment rates, length of call times, and limited ability to track disposition/ outcomes of the calls. For example, in 2023, 35% of the 2,669 calls received from Athens, Hocking, and Vinton counties had call outcomes recorded.

Mobile Crisis

Athens Mobile Crisis

Hopewell currently operates a mobile crisis team in Athens County based on the CAHOOTS staffing model of a behavioral health clinician and paramedic. [19]

The CAHOOTS Model

In 1989, the City of Eugene, Oregon, developed an innovative community-based public safety system to provide mental health first response for crises involving mental illness, homelessness, and addiction.

The CAHOOTS (Crisis Assistance Helping Out On The Streets) model mobilizes two-person teams consisting of a medic (a nurse, paramedic, or EMT) and a crisis worker who has substantial training and experience in the mental health field. The CAHOOTS teams deal with a wide range of mental health-related crises, including conflict resolution, welfare checks, substance abuse, suicide threats, and more, relying on trauma-informed de-escalation and harm reduction techniques. CAHOOTS also handles non-emergent medical issues, avoiding costly ambulance transport and emergency room treatment. CAHOOTS will collaborate or refer to law enforcement for high-acuity behavioral health crises.

[19] What is CAHOOTS? - White Bird Clinic

The two-person team operates Monday through Friday 8am–4pm and responds in the community or at the Hopewell Clinic at the request of individuals in crisis, clinicians, concerned community members, law enforcement, or self-dispatch from listening to the 911 Public-Safety Answering Point (PSAP).

Table 3. Mobile Crisis Ideal Features

Mobile Crisis: Ideal Features	
Focus Area	**Current**
Operates 24/7/365	
Includes a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of the operation.	☑
Incorporate peers within the team.	
Responds without law enforcement accompaniments unless special circumstances warrant inclusion.	☑
Responds where the person is, and do not restrict services to select locations within the region or days/times.	
At least 70% of mobile crisis dispatches are resolved in the field.[20]	
Responds to calls within one hour (urban) to 90 minutes (rural) at least 90% of the time.	
Offers triage/screening, assessment, de-escalation/resolution, peer support, coordination with medical and behavioral health services, safety planning, counseling on access to lethal means, and follow-up.	☑
Connects individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.	☑
Schedules outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care.	☑
Utilizes telehealth resources when in-person crisis response is not feasible.	☑

[20] Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies | Psychiatric Services (psychiatryonline.org).

Significant Data Points:

From 2021 to 2023, the number of mobile responses decreased 38%, from 184 to 114.

Table 4. Mobile Response Disposition Data from 2022 and 2023

43%	Community Resolution
39%	Transport to the Emergency Department
9%	Transport to Inpatient Psychiatric Care
8%	Transport to Crisis Respite

Identified Gaps:

- The mobile crisis team currently operates Monday through Friday 8am–4pm. This timeframe misses instances when crises often occur.
- The mobile crisis team is currently staffed by a clinician and paramedic, no current utilization of a peer support specialist.
- The mobile crisis team resolved 39% of calls in the field in 2022, and 48% of calls in 2023. Call response time, including whether a team responds within one hour, is not currently collected or analyzed.

Hopewell Crisis Pre-Screeners

In addition to the Athens County Mobile Crisis Team, Hopewell also operates a crisis pre-screening team that conducts assessments for potential psychiatric inpatient placement. In the AHV region this team is comprised of three full-time pre-screeners and a pool of PRN staff providing 24/7 service. Currently, crisis pre-screeners assess via telehealth in emergency departments and correctional facilities and assess in-person or via telehealth at the Hopewell Clinics in Athens, Hocking, and Vinton counties. Crisis pre-screeners complete several tasks of a mobile crisis team member aligning them most closely with features of a mobile team and therefore being compared against such standards. In several states, the role of mobile crisis and crisis pre-screener is combined into a single crisis team member position.

Table 5. Mobile Crisis Ideal Features Applied to Crisis Pre-Screeners

Mobile Crisis: Ideal Features	
Focus Area	**Current**
Operates 24/7/365	☑
Includes a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of the operation.	☑
Incorporate peers within the team.	

Mobile Crisis: Ideal Features	
Focus Area	**Current**
Responds without law enforcement accompaniments unless special circumstances warrant inclusion.	☑
Responds where the person is, and do not restrict services to select locations within the region or days/times.	
At least 70% of mobile crisis dispatches are resolved in the field.[21]	
Responds to calls within one hour (urban) to 90 minutes (rural) at least 90% of the time.	
Offers triage/screening, assessment, de-escalation/resolution, peer support, coordination with medical and behavioral health services, safety planning, counseling on access to lethal means, and follow-up.	☑
Connects individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.	☑
Schedules outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care.	☑
Utilizes telehealth resources when in-person crisis response is not feasible.	☑

Significant Data Points:

The number of crisis pre-screens decreased 22% from 2022 to 2023.

Table 6. Crisis pre-screens 2022 and 2023

	2022	2023
Total Pre-Screens Completed	2917	2392
Average Pre-Screens/Month	243/month	200/month
Percent of Pre-Screenings resulting in Inpatient Placement	31%	41%
Number of Pre-Screenings resulting in Crisis Respite Placement	9	3

[21] Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies | Psychiatric Services (psychiatryonline.org).

Identified Gaps:

- Crisis pre-screeners are a team of clinicians trained as health officers and provide their assessment services independently. Peer Support Specialists are not a part of the crisis pre-screen model.
- Crisis Pre-screeners operate primarily via telehealth in emergency departments and correctional facilities, restricting in-person community responses.
- Currently, the response time of a crisis pre-screen is either not collected or not available, precluding the ability to assess if crisis pre-screens occur within an hour of request 90% of the time.

Mobile Response Stabilization Services

An ideal behavioral health crisis system offers timely and effective services capable of addressing an individual's unique needs. Mobile response and stabilization services (MRSS) was developed in 2018 as a new service in Ohio's youth behavioral health system of care. MRSS is integrated as an essential service within Ohio's system of care to fill a gap for families seeking services for urgent behavioral situations before they become unmanageable emergencies. MRSS is instrumental in averting unnecessary emergency department visits, out of home placements, and placement disruptions, and in reducing overall system costs. MRSS works to keep a child, youth, or young adult safe at home, in the community, and in school whenever possible.[22]

The MRSS team's ability to be dispatched and provide services in multiple locations reduces the likelihood of an individual in crisis interacting with law enforcement and/or seeking care through the emergency department. Once an MRSS team has helped to stabilize the individual and conduct an assessment, the team coordinates a follow-up care. plan 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 handoffs are critical to facilitate while scheduling aftercare appointments to ensure the person served can verify information and request additional context as needed. Warm handoffs 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, affording the person served an opportunity to begin building a relationship with the new service provider and are proven to decrease no-shows.[23]

Care coordination is a cornerstone of successful MRSS services, as teams connect individuals to medical and/or behavioral health services, and when appropriate, facilitate warm handoffs to ensure continuity of care. Staff on MRSS teams have knowledge of community resources and understand how to access different services in the crisis system of care.

[22] MRSS | Practice Standards - Wraparound Ohio.

[23] 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.

Table 7. Mobile Crisis and Stabilization Services Ideal Features

Mobile Response and Stabilization Services: Ideal Features	
Focus Area	**Current**
Operates 24/7/365	
Delivered to any young person under the age of 21.	☑
Collaboration across community systems with formal and informal linkages between child-serving agencies and programs, including across administrative and funding boundaries.	☑
The young person and family and/or another referrer define what constitutes a crisis.	☑
Provided at the location of the young person in distress or at a community location preferred by the youth, family, or other referrer.	☑
Present of the three MRSS activities/phases: Screening and Triage, Mobile Response, and Ongoing Stabilization.	☑
Screening, triage, and mobile response can last for up to 72 hours.	☑
Stabilization activities lasts for up to six weeks.	☑
Young people and their families are full partners in all aspects of the planning and delivery of their MRSS services.	☑
Offers culturally and linguistically appropriate services to all young people and families that receive MRSS.	☑
Includes a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of the operation and a peer support specialist.	☑

Significant Data Points:

Mobile response and stabilization services (MRSS) have been positively received by the communities the program serves. Stakeholders have a strong desire to expand operational hours, ensuring specialized service is available to youth and families regardless of the time of day. Since MRSS are not office-based (the most common barrier to access) lack of transportation, is reduced. From 2022 to 2023, 89% of families reported being satisfied with the MRSS services they received, which aligns closely to the state average of 88%. Perhaps the most encouraging data available on Hopewell Health's MRSS program is that 97% of MRSS responses provided resolution outside of psychiatric inpatient treatment in 2022 and 2023.

Identified Gaps:

- MRSS currently operates with limited hours, Monday through Friday 8:00am to 5:00pm. When crisis services are not operational 24/7/365, the community is often challenged to navigate a non-crisis-oriented system during non-operational hours. This challenging navigation can result in dissatisfaction and a reduced likelihood for engaging with the crisis system in the future.
- A hallmark feature of MRSS is a willingness to engage youth and adolescents presenting with acute systems, rather than operating from a risk-averse culture. Hopewell Health's current MRSS program design refers families to take youth to an emergency department for a hospital pre-screen if the acute symptom of suicidal ideation with an active plan is reported.

Crisis Respite/Adam-Amanda Center

Hopewell's Crisis Respite and the Adam-Amanda Center are two programs run with the same employees. Staff work in the same 16-bed building with beds flexibly assigned based on need.

Crisis Respite is a hospital diversion program that accepts referrals from Hopewell clinicians, crisis pre-screeners, and mobile crisis, while providing a hospitable environment. Individuals can stay at the Crisis Respite for up to 14 days with the goal of preventing further escalation of a crisis and prevent hospitalization.

The Adam-Amanda Center serves as a stepdown from inpatient hospitalization, designed to provide further stabilization and enable successful transitions back into the community. Individuals can stay at the center for up to 90 days.

Table 8. Crisis Stabilization Unit Ideal Features

Crisis Stabilization Unit (CSU): Ideal Features	
Focus Area	**Current**
Accepts referrals and admissions 24/7/365.	
Serves individuals for a length of stay longer than 24 hours.	☑
Does not require medical clearance prior to admission, instead assess and support for medical stability while in the program. Or, if referred from the ED, admit those who would have been discharged home if not for mental health crisis.[24]	
Assumes that co-occurring mental health and substance use disorders will be prevalent in the population they serve and welcomes individuals who may be actively using substances, including those who may be intoxicated. Assesses withdrawal symptoms and can manage mild to moderate withdrawal symptoms with consultation from on-call medical staff.[25]	

[24] Crisis Residential Best Practices Handbook.
[25] Ibid.

Crisis Stabilization Unit (CSU): Ideal Features	
Focus Area	**Current**
Operates in an unlocked, less restrictive, and more home-like setting than a hospital.	☑
Functions as both a diversion and a stepdown from inpatient hospitalization.	☑
Employs a multidisciplinary team including medication prescribers, nurses, clinicians, and care providers.	
Staffing model includes peer support specialists or recovery coaches.	☑
Screens for suicide risk and complete comprehensive assessment and planning when indicated.	
Screens for violence risk and complete comprehensive assessment and planning when indicated.	
Offers crisis intervention and support, connection to community resources, and treatment services to facilitate the resolution of a crisis.	☑
Employs clinical models that emphasize the recovery model, trauma-informed care, and evidenced-based practices such as CBT.	
Offers therapeutic engagement through psychoeducational groups, group and individual therapy, and recreational activities.	☑

Crisis Respite/Adam-Amanda Center Significant Data Points

From 2022 to 2023 Crisis Respite and Adam-Amanda Center's bed occupancy rate decreased from 67% to 29%. The Adam-Amanda Center had 12 successful, planned discharges in 2023.

Crisis Respite/Adam-Amanda Center staff reported 85% of admissions were for the Adam-Amanda Center, but 2023 data showed that 39% of admissions were for the Adam-Amanda Center. This discrepancy in perception may be due to the Adam-Amanda Center's longer length of stay.

Table 9. Crisis Respite Admission and Denials Data

		2022	2023
Crisis Respite	**Admissions**	**68**	**48**
	Denials	2	0
	Denial Rates	3%	0%
	Length of Stay (in days)	6	8
	Transferred to IP care	10%	4%
	Unplanned Discharge *(asked to leave by staff, leaving without disclosing destination)*	12%	15%
	Client Satisfaction Rate	*unknown*	*unknown*

Table 10. Adam-Amanda Center Admission and Denials Data		2022	2023
Adam-Amanda Center	**Admissions**	**79**	**31**
	Denials	30	26
	Denial Rates	27%	46%
	Length of Stay (in days)	43	35
	Transferred to IP care	30%	29%
	Unplanned Discharges *(asked to leave by staff, elopement)*	18%	23%
	Client Satisfaction Rate	*unknown*	*unknown*

Identified Gaps:

- Crisis Respite/Adam-Amanda Center does not admit new clients 24/7. The Adam-Amanda Center requires extensive medical clearance: all lab work and imaging from the ER and hospital, history and physical from the ER or from MD at the psychiatric facility, and the last 30 days of progress notes for consideration of admission.
- No current protocols to assess withdrawal symptoms and manage mild to moderate withdrawal symptoms. Potential alcohol and withdrawal symptoms are exclusionary criteria.
- Medication providers have dedicated time at Adam-Amanda Center, but Crisis Respite guests do not see a medication provider, limiting Crisis Respite's multi-disciplinary treatment model.
- Primary suicide screening tool reported to be the question: "Can you keep yourself safe here? "No violence assessment tools, or process reported.
- Current programming focus on psychoeducation and skills for activities of daily living. Currently, 1:1 evidenced based therapy such as CBT, DBT, CAMS, etc. is not a part of treatment as usual.

Introduction

Methods

Results & Analysis

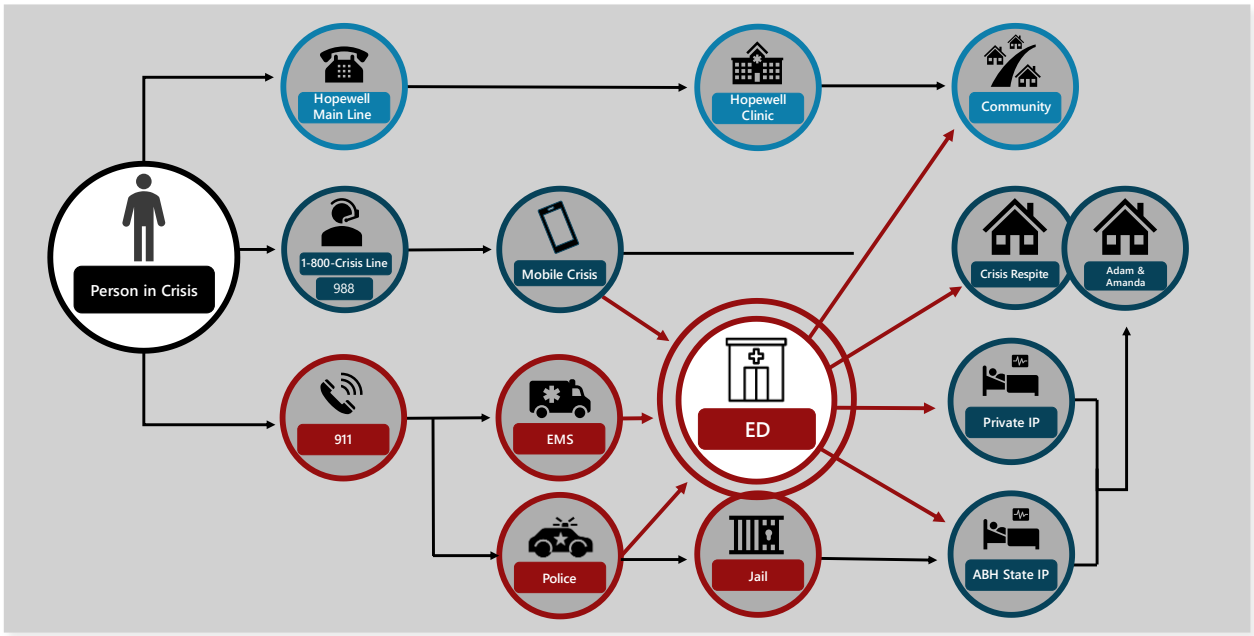
Discussion & Recommendations

Appendix

Discussion

The hub of the current Athens-Hocking-Vinton Behavioral Health Crisis System is the local emergency department. Recommendations about the future of the AHV crisis system will be best formed by first engaging a brief discussion of the past and present state of crisis care. Crisis partner interviews and data offered a story of how the current system came to be; the best practice Triple Aim of Healthcare offers a lens through which to understand the implications of the current system.

Figure 11. Current Hub of the AHV Crisis System



The Past Story

Over the past 10 years, two important shifts in crisis care occurred in the AHV region: Local inpatient treatment options closed, forcing people to seek inpatient care out of county, and community crisis care utilization decreased.

Appalachian Behavioral Health (ABH), the legacy institution of the Athens Asylum, holds a rich history of adapting its service to meet the needs of the broad community it serves. Ten years ago, ABH primarily provided emergency crisis care for community civil commitments (approximately 70% of admissions). Law enforcement could drop off at ABH, and O'Bleness could walk over individuals who needed involuntary treatment after minimal waits.

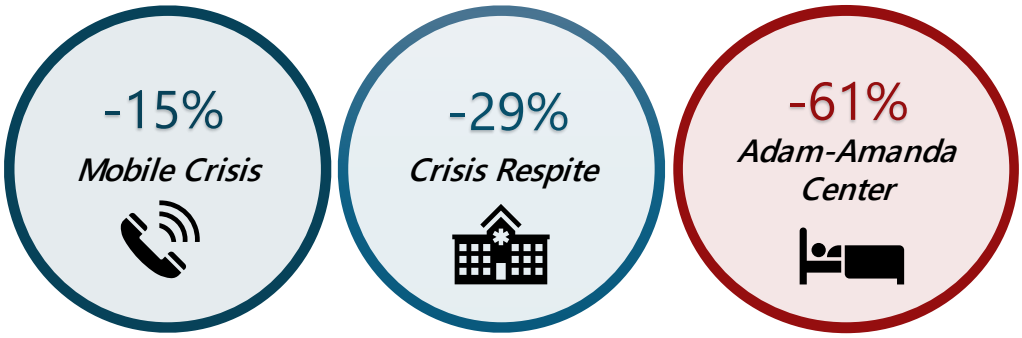
Over time, ABH began to have forensic competency restoration cases assigned to their facility by the State. The number of competency restoration referrals has increased steadily over the past decade. ABH is uniquely able to meet this need and does not control the volume of cases ordered to the facility. In addition to competency restoration, ABH continued to serve forensic commitments of those incarcerated individuals needing emergency stabilization, and those deemed Not Guilty by Reason of Insanity (NGRI). The NGRI admissions, which tend to have longer

stays, have doubled in the past year, and emergency jail stabilization admissions has been the highest utilizers of state psychiatric services. Currently 80% of admissions to ABH are forensic, and with ABH adapting to meet this forensic need, the result has been a displacement of civil commitment stabilization beds.

With a focus on forensic competency restoration, the AHV community's closest consistently available psychiatric inpatient treatment moved from ABH to a network of hospitals in Columbus 90 minutes away.

The second important shift in the AHV region occurred when there was a decrease in community crisis care services utilization. In 2023, community-based crisis services engaged 193 individuals, as utilization decreased across services from 2022:

Figure 12. Decrease in Community Crisis Care services Utilization from 2022-2023



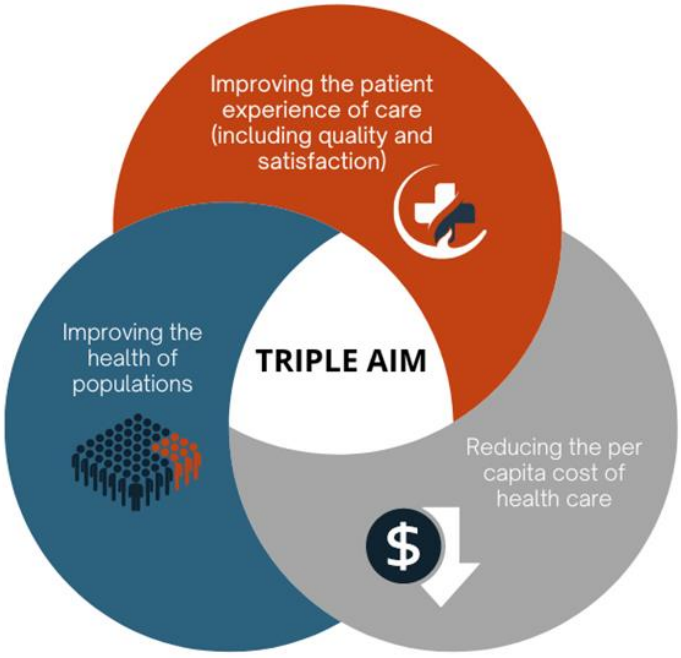
During this same timeframe, law enforcement in Athens County (Athens Police Department, Ohio University Police Department, and Athens County Sheriff) engaged 1,455 individuals in some level of mental health distress/crisis, an increase from of 3% since 2022.

The shifts in the AHV region resulted in the emergency department acting as the de facto hub of behavioral health crisis care. With less use of community-based crisis care (mobile and crisis respite), more individuals go to the ED for assessment and stabilization. With more individuals coming to the ED and less local and easily accessible psychiatric inpatient care, individuals either wait longer in the ED for out of county placement or are discharged home to await outpatient care. To increase efficiency and decrease wait time, emergency departments are shifting crisis pre-screening in-house, further centralizing their role.

Current Implications of the Past Shift in Crisis Care

The Triple Aim of Healthcare is a conceptual model to identify levers or drivers in effective health care systems. The goals of the Triple Aim are to improve health outcomes, client experience, and cost efficiency. To best understand the implications of the current AHV crisis system and its primary reliance on law enforcement and emergency departments, the cost, outcomes, and experiences must be considered.

Figure 13. Triple Aim of Healthcare Model



Cost: On a systems level, law enforcement and emergency departments are the most expensive community options for first responders, transportation, and clinical assessment. On an individual level, emergency department bills make this pathway the most expensive option compared to clinic or home-based crisis intervention, assessment, and stabilization.

Outcomes: The current primary pathway utilizes those with the most training in behavioral health crisis care (clinicians) the least. Additionally, this pathway has constraints in how much direct behavioral health treatment can be administered for potentially life-threatening crises. Typically, crisis pre-screeners in emergency departments will complete a safety plan with individuals before they leave. While important, safety plans do not treat or resolve the source of an individual's crisis. A key metric in assessing outcomes is the frequency of individuals not having their crisis resolved, resulting in high repeat use of the crisis system. Limited data is collected on this in the AHV region, but all stakeholders and providers mentioned high repeat utilization as a challenge.

Experience: Individuals who had gone through the primary crisis care pathway described it as long, unhelpful, and, at times, aversive. Crisis partners, including emergency department staff, quickly identified both the value of emergency departments as accessible, safe treatment sites, and the limitation that emergency departments were not designed for behavioral health crisis intervention and boarding.

Recommendations for the Crisis System

Based on the analysis and discussion of the current behavioral health crisis system in Athens, Hocking, and Vinton counties, TBD Solutions offers the following recommendations:

1. Convene Crisis Partners around Data-Driven Decision Making

The residents and agencies of the Athens-Hocking-Vinton region face a shared challenge: how to best help those experiencing a behavioral health crisis. Several agencies including law enforcement, emergency medical services (EMS), emergency departments, universities, behavioral health agencies, and specialized behavioral health crisis teams currently engage this challenge. Collectively, these crisis partners can identify system-wide challenges and implement meaningful solutions to effectively and efficiently help those in crisis.

TBD Solutions recommends the 317 Board convene each county's crisis partners and lead three crisis-specific workgroups that focus on data-driven decision making to improve care coordination in the crisis system. These crisis workgroups should convene monthly to enable a regular rhythm of responding to emerging issues, while allowing time between meetings to gather data and implement solutions. The 317 Board should plan to launch monthly meetings by July 2024. The meetings will be most effective if held in person and at central locations in each county. Addressing difficult problems and strengthening professional partnerships within the crisis community is achieved more efficiently and effectively when partners are sharing the same physical space.

Table 11. AHV Crisis Partner Agencies to Invite

Law Enforcement	• 911 Public-Safety Answering Points (PSAPs) • Police Departments • Sheriff's Office • Jails • Judges
Emergency Medicine	• Emergency Medical Services (EMS), • Emergency Departments (ED)
Community-Based Crisis Services	• 988 • Mobile Response and Stabilization Services (MRSS) • Mobile Crisis/Crisis Pre-Screeners • Crisis Respite
Psychiatric Inpatient	• Appalachian Behavioral Health • Columbus facilities
Individuals Served	Representatives of those who have received crisis services in the past, such as a Certified Peer Support Specialist.

Data-driven decision making

The purpose for the workgroup is paramount to its success. The 317 Board must demonstrate the value of the convening by structuring it around crisis data sharing by all participants in order to make system-wide decisions that solve identified problems. An expectation must be set that sharing data is not to facilitate blame, but to identify ways in which the group can help each other improve the crisis system. To begin, the Crisis Reliability Indicators Supporting Emergency Services (CRISES) framework offers a guide for common data points to request that workgroup members bring.[26] TBD Solutions recommends the 317 Board implement a phased approach, beginning with five outcome measures per agency. Once established, the 317 Board can introduce an additional five outcome measures. Before the Crisis Partners meeting is launched, the 317 Board should offer to assist in setting up the collection and reporting of the outcome measures with each partner.

Table 12. CRISES Framework and Outcome Measures

Phase I					
CRISES Outcome Measures	**988 Center 911 PSAP**	**Crisis Teams**	**First Responders (LE/EMS)**	**Emergency Depts**	**Crisis Units Psychiatric IP**
Accessible *(Utilization)*	Number of behavioral health crisis calls	Number of mobile responses, crisis pre-screens	Number of mental health related dispatches	Number of mental health related admissions	Number of admissions
Timely *(Response Time)*	Average time to answer	Average time from dispatch to individual in crisis	Average time from dispatch to scene	Average length of stay for mental health admits	Average time from referral to acceptance
Safe *(Violence Incidents)*	Number of self-harm incidents by individuals served	Number of self-harm incidents by individuals served	Number of self-harm incidents by individuals served	Number of self-harm incidents by individuals served	Number of self-harm incidents by individuals served
	N/A	Number of staff harm incidents	Number of staff harm incidents	Number of staff harm incidents	Number of staff harm incidents

[26] Balfour ME, Tanner K, Jurica PJ, Rhoads R, Carson CA. Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs. Community Ment Health J. 2016 Jan;52(1):1-9. doi: 10.1007/s10597-015-9954-5. Epub 2015 Sep 29. PMID: 26420672; PMCID: PMC4710652.

Least Restrictive *(Disposition)*	Number/ Percent of calls resolved over the phone	Number/ Percent of responses resolved in the community	Number/ Percent of responses resolved in the community	Number/ Percent of mental health admissions with planned discharge to community	Number/ Percent of admissions with planned discharge to community

Phase II

CRISES Outcome Measures	988 Center 911 PSAP	Crisis Teams	First Responders (LE/EMS)	Emergency Depts	Crisis Units Psychiatric IP
Effective *(Recidivism)*	Identify top 10 utilizers/ past month	Identify top 10 utilizers/ past month	Identify top 10 mental health utilizers/ past month	Identify top 10 mental health utilizers/ past month	Identify top 10 utilizers/ past month
	Identify top 3 causes of high utilization	Identify top 3 causes of high utilization	Identify top 3 causes of high utilization	Identify top 3 causes of high utilization	Identify top 3 causes of high utilization
Effective *(Satisfaction)*	Number/ Percent of individuals satisfied with services	Number/ Percent of individuals satisfied with services	N/A	Number/ Percent of individuals satisfied with services	Number/ Percent of individuals satisfied with services
Partnership *(Agency Handoffs)*	Number of referrals to crisis partners	Number of referrals to crisis partners	Number of referrals to crisis partners	Number of referrals to crisis partners	Number of referrals to crisis partners
	Number of successful referrals to crisis partners	Number of successful referrals to crisis partners	Number of successful referrals to crisis partners	Number of successful referrals to crisis partners	Number of successful referrals to crisis partners

Establishing the data collections processes will take time and effort by each crisis partner. Crisis partners will need to dedicate administrative time to define, collect, analyze, and share the data points, and technical assistance from the 317 Board may be required. Emphasizing the community value of sharing this data to identify and solve problems will be vital, and celebration of each crisis partner achieving this implementation warranted.

The 317 Board will additionally need to create a method to compile and present the shared data, from spreadsheets to potential visual data maps, to facilitate conversation at the meetings. In meeting discussions, once a need is identified by the data (i.e. long lengths of stay at an emergency department), the response should be for each crisis partner to ask, "how can my agency help with that data point?" Following the emergency department example, if O'Bleness and HVCH both share long lengths of stay at their emergency department, the next step would be for the other partners to ask how their agency can help reduce the ED length of stay.

The goal of the Crisis Partners meeting and of an improved crisis system is to enable each agency to do more of what they are best at. Increasing communication and data transparency will result in faster identification of problems that come up in which crisis partners are providing care outside of their specialty to fill a gap. Once identified, crisis partners can find and implement solutions so that each agency is spending more time and effort within their specialty, and effectively handing off situations to other's specialties. Partnership makes specialization possible, a scenario that benefits everyone involved.

Table 13. The Goal of the Crisis Partners Meeting

Crisis Partner	MORE Time Spent	LESS Time Spent
Emergency Departments	Treating medical emergencies	Medical clearances and boarding for medically stable individuals in a behavioral health crisis
Law Enforcement Officers	Serving and protect the public	Being the first responder and transport for low acuity behavioral health crises
911 PSAP's	Triaging and dispatching support for those in a life-threatening emergency	Behavioral health support and de-escalation
Mobile Crisis Responders	Timely crisis intervention when and where they are needed most	Not being available
Crisis Units	Low barrier access and specialized intervention to resolve an individual's crisis	Not being available
Individuals in a Crisis	Receiving timely, accessible, least restrictive, effective crisis care	With police and sitting in emergency departments instead of receiving treatment

2. Enhance the Accessibility of Community Crisis Care

TBD Solutions recommends that Hopewell Health enhance access to community-based crisis services by making strategic shifts within Crisis Respite, the Adam-Amanda Center, the Crisis Pre-Screeners and Mobile Crisis Team to align with national best practices.

Enhancing Access to Crisis Respite and The Adam-Amanda Center

Hopewell Health should increase accessibility to Crisis Respite and the Adam-Amanda Center through process improvement, expanding suicidal acuity capability, and specific funding advocacy. These steps can be achieved by implementing the following strategic shifts:

Table 14. Strategic Shifts for Crisis Respite and Adam-Amanda Center

Increase Accessibility by Process Improvement	Operate Crisis Respite and Adam-Amanda Center as separate services, with each having a set number of program beds.
	Write the specific admission and denial criteria for Crisis Respite, Adam-Amanda Center, and mobile crisis; making all public facing and offering education to community partners.
	Revisit the Adam-Amanda Center maximum length of stay to better align with the national average. The majority of crisis residential programs, including those who operate as a post-hospital step down, have a length of stay less than 10 days.[27] The value of an additional 20, 50, or 80 days should be clearly demonstrated with outcome data if they are to be used.
Increase Accessibility by Expanding Suicidal Acuity Capability	To increase safety and reduce program risk, implement 30-minute safety checks for all individuals served in Crisis Respite.
	Implement evidenced based suicidality screening and assessment for Crisis Respite and the Adam-Amanda Center (i.e. C-SSRS, SAFE-T, CAT).
	Enhance the treatment programming of Crisis Respite by incorporating medication evaluation appointments as needed for guests.
	Enhance the treatment programming of both programs by incorporating a higher percentage of clinical groups (CBT, DBT).
Increase Accessibility via Funding & Advocacy	Calculate cost of ideal service model (staffing, overhead, etc.), compare to current funding, and use the data to inform advocacy to the 317 Board, local funders, and OhioMHAS.

[27] TBD Solutions. (2018). Crisis Residential Best Practices Handbook. Crisis Residential Best Practices Toolkit (crisisnow.com), pg 17.

Enhancing Access to Crisis Pre-screeners/Mobile Crisis

To increase the accessibility of crisis pre-screening and mobile crisis in Athens County, Hopewell Health should implement three strategic shifts:

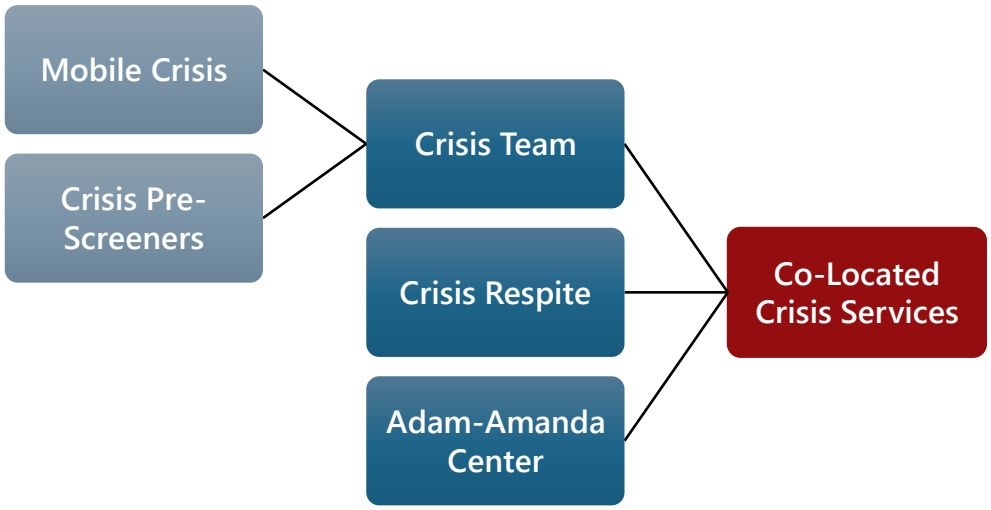
Table 14. Strategic Shifts for Crisis Pre-screeners and Mobile Crisis

Increase Accessibility by Strategic Combination	Combine the full-time employees of the crisis pre-screeners and mobile crisis team into one crisis team. This Crisis Team's mission would be to provide assessment and intervention for crisis resolution. The team would accomplish this mission by responding to emergency departments, law enforcement, jails, and the community via 988.
Increase Accessibility by Cross-training Embedded Staff	Crisis pre-screening training and certification for staff members embedded in other agencies (jail, schools). This would increase the number of face-to-face assessments when needed and provide more personal interactions of care.
Increase Accessibility by CAHOOTS Alignment	Expand access to the current CAHOOTS model co-response by aligning with the CAHOOTS model's direct dispatch by 911 Public-Safety Answering Point (PSAP)s. Hopewell should pursue regularly scheduled meetings with PSAP or EMS leadership to identify current barriers to direct dispatch and work to resolve those challenges. This direct referral source would open the door for more referrals of this unique and valuable service.

Strategic Program Shifts to Enhance Overall Accessibility

Crisis services operate like a firehouse, with intense, intermittent, and often unpredictable cadences of demand. To respond to this dynamic, Hopewell Health should co-locate their crisis team at the Adam-Amanda Center so that they can assist the Crisis Respite if not otherwise engaged on a call.

Figure 14. Strategic Program Shifts and Operational Structure



This co-location approach allows for cross-trained accessible staff. For instance, peer support specialists could be hired and trained to co-respond with a crisis team clinician when the paramedic is not available, to assist with 30-minute checks when not on a call and/or complete 988 follow-up calls.

Explore Crisis Partnerships

The translation of urban innovations to rural settings often overlooks the very factor that separates the two communities: the number of people. The AHV region will not have the same workforce pool as compared to urban centers to draw upon for staffing a community-based crisis system. To help combat the potential shortage of options, AHV must lean into local partnerships among a broad array of agencies and services. Building upon the collaboration in the aforementioned monthly crisis partner meetings, next steps include:

Cost sharing for embedded positions. To decrease wait time for a crisis assessment/ intervention at Hocking Valley Community Hospital, or potentially Holzer, the hospital and Hopewell could both contribute to the funds for one crisis counselor who would be stationed at the hospital.

Co-location of interagency services. As agencies grow and develop initiatives, seeking opportunities to co-locate partners in the same space can increase efficiency, communication, and partnership.

Conclusion

Behavioral health crisis services shoulder a heavy set of responsibilities, solving complex problems and navigating diverse systems. The impact of effective behavioral health crisis services is nothing less than saving lives. Advances in research and access to best practices allow communities like Athens, Hocking, and Vinton counties to make informed decisions about how to develop, sustain, and improve an effective crisis system.

The real limitations of funding and workforce must be acknowledged without causing despair. With intentional communication between agencies, thoughtful partnerships, and strategic combining and co-locating of services, the crisis system will become more efficient and effective with its current workforce and resources.

The best-run crisis systems in the country continuously seek improvement and adapt to the ever-changing landscape of behavioral healthcare. Athens holds a rich legacy of this very endeavor. Together, ongoing steps can be taken to meet the needs of those experiencing a behavioral health crisis with increasing efficiency, effectiveness, and compassion.

Introduction

Methods

Results & Analysis

Discussion & Recommendations

Appendix

Appendix A: Site Tours & Interview Agencies

Crisis Partner Site Tours

- Crisis Respite/Adam-Amanda Center
- O'Bleness Emergency Department
- Hocking Valley Community Hospital Emergency Department
- Appalachian Behavioral Health
- Hopewell Athens County Clinic
- Hopewell Hocking County Clinic
- Hopewell Vinton County Clinic
- Columbus Springs Psychiatric Hospital
- Riverside Methodist Hospital Emergency Department
- NetCare Crisis Stabilization Unit

Crisis Partner Interview Agency Representatives

Table. 15 Stakeholders Interviewed in AHV Region

Law Enforcement	Athens County Sheriff's Office OU Police Department Athens Police Department Logan Police Department Vinton County Sheriff Southeast Ohio Regional Jail
Emergency Medical	O'Bleness Emergency Department (3) Hocking County EMS Hocking Valley Community Hospital Emergency Department
Advocacy/Peer Agencies	NAMI Athens The Gathering Place
Emergency Shelters	Hocking Hills Inspire Shelter Sojourners Care Network

Individuals Served by the Crisis System	**6 individuals** interviewed at Crisis Respite/Adam-Amanda Center **8 individuals** interviewed at The Gathering Place. **8 individuals** took place in two four-person focus groups at The Gathering Place **11 surveys** were completed by individuals who had received crisis services and were offered the survey by their Hopewell outpatient therapist.
Crisis Providers (Hopewell)	Chief Clinical Officer Crisis Director Crisis Respite/Adam-Amanda Center Director 988 Supervisor MRSS Supervisor Crisis Counselor Jail Liaison Hocking County School Counselor Hospital Liaison
Mental Health Providers	Appalachian Behavioral Health (2) Columbus Springs Psychiatric Hospital Integrated Services for Behavioral Health Hopewell Athens Adult Clinic Director Hopewell Athens Youth Clinic Director Hopewell Hocking County Clinic Director Hopewell Vinton County Clinic Director Ohio University Counseling Center

Appendix B: Data Sources

Crisis Partners Data Submissions

- 317 Board (pre-screening data)
- Athens Police Department
- Ohio University Police Department
- Athens County Sheriff's Office
- Hocking County EMS
- O'Bleness Emergency Department
- Crisis Respite/Adam-Amanda Center
- 988 Call Center
- Athens Mobile Crisis

Public Data Sources

- The Census Bureau's American Community Survey (2017-2021 data)
- Centers for Disease Control and Prevention PLACES project – which draws on the 2021 Behavioral Risk Factor Surveillance System
- The Ohio Department of Health Drug Overdose Report, County Health Rankings and Roadmaps
- Local community health needs assessments
- Local community health improvement plans

Additional Data Analysis Sources

988 calls received originating from an Athens County area code. This data comes from the 988 iCarol database.

Mobile Crisis responses occurring in Athens County. This data comes from 317 Board Mobile Crisis Dispatch data generated by Hopewell Health cross-referenced with a data request to Hopewell regarding mobile crisis.

EMS transports specifically coded to a primary mental health need. This data comes from Athens County EMS.

Law Enforcement dispatches due to a mental health need. This data comes from submission by Athens County Sheriff's Office, Athens County Police Department, and the Ohio University Police Department. The following considerations and logic was used to aggregate law enforcement data from three agencies: First, each law enforcement agency codes their dispatches independently and a decision had to be made of what codes to include. Dispatch codes such as: Blue Slip, Pink Slip, Suicide Attempt, Suicide Threat, Mental Patient, and Welfare check were included. The second consideration was that some welfare checks are of course not behavioral health crisis related, but law enforcement agencies could not parse out behavioral health related welfare checks from non-behavioral health related welfare checks. A common report in interviews was that a significant amount of welfare checks included behavioral health crises. To balance non-behavioral health crisis welfare checks in the data, other call types that at times have behavioral health crises

involved, including trespassing, runaway/unruly child, and domestic violence were excluded from the data. The resulting number of behavioral health crisis involved calls is considered a conservative estimate (less than 10% of total volume) compared with Law Enforcement leadership's consistent estimate that 20%-30% of their call volume involved behavioral health crises.

Hopewell Athens Clinic crisis pre-screens occurring on site. This data comes from 317 Board crisis pre-screen data generated by Hopewell Health.

Emergency Room crisis pre-screens for psychiatric inpatient treatment occurring at O'Bleness Emergency Department. This data comes from the 317 Board and offers a conservative number of behavioral health crises in the emergency department. Based on interviews, some individuals who present to the emergency department in a behavioral health crisis can assessed, treated, and released without a crisis pre-screen.

Dispositions/Referrals to the community, Crisis Respite, one of the private psychiatric hospitals in Columbus, or Appalachian Behavioral Health State Psychiatric Hospital.

Appendix C: Client Survey

Crisis Lived Experience Survey

Hello and welcome to the Crisis Service Experience Survey. TBD Solutions has been contracted by the 317 Alcohol Drug Addiction and Mental Health (ADAMH) board to assess the behavioral health crisis system for Athens, Hocking, Vinton, Gallia, Jackson, and Meigs counties. **The most important voice we know to listen to is the one of those who have received crisis services.**

This survey is asking about your most recent experience in accessing and receiving crisis services. The survey is voluntary, and you may stop taking it at any point. Your answers will go directly to TBD Solutions and will not individually be shared. The combined results will be shared with the 317 board and crisis service providers to help improve crisis services. Thank you for considering sharing your voice through this survey.

1. What county did you access crisis services?

- ❑ Athens County
- ❑ Hocking County
- ❑ Vinton County
- ❑ Gallia County
- ❑ Jackson County
- ❑ Meigs County
- ❑ Another County
- ❑ I don't know

2. Why did you seek crisis services?

- ❑ Suicidal Thoughts
- ❑ Suicide Attempt
- ❑ Depression
- ❑ Anxiety
- ❑ Other severe mental health symptoms
- ❑ Conflict with family or friends
- ❑ Substance Use
- ❑ I did not seek crisis services
- ❑ Other: _____

3. How did you access crisis services?

- ❑ I called 911
- ❑ I called 988
- ❑ I called a crisis hotline
- ❑ I called my Outpatient MH Provider
- ❑ I walked into an ER
- ❑ I walked into my outpatient MH Clinic
- ❑ The police showed up (I didn't call them)

4. How would you rate your experience with accessing crisis services?

- ❑ Very Bad (1)
- ❑ Bad (2)
- ❑ Neither good nor bad (3)
- ❑ Good (4)
- ❑ Very good (5)

5. Why did you choose that rating?

6. What treatment did you receive to treat your crisis? (Select all that apply)

- ❑ Medication management
- ❑ 1:1 Therapy
- ❑ Group Therapy
- ❑ Discharge planning/connection to resources
- ❑ Safety Planning
- ❑ Restricting Access to Lethal Means
- ❑ Talking with a Peer Support Specialist

7. What helped you the most to resolve your crisis?

8. What helped you the least to resolve your crisis?

9. What would have improved crisis services for you?

10. Did you attend or do you plan to attend your outpatient follow-up appointment after your stay?

- ❑ Yes
- ❑ No

11. Why or why not?

12. Would you like to talk more over the phone? We would love the opportunity to do a follow-up 30-minute phone interview. If so, please leave your email or phone number here: