AGENDA

Franklin County Mental Health and Addiction Crisis Center

Steering Committee

January 28, 2021 3:00 PM – 5:00 PM
Zoom Meeting
(Meeting ID and password sent via email to attendees)

MEETING OBJECTIVES:

- Overview of project status
- Final workgroup updates
- Transition to joint-quarterly meetings with PCES

3:00 p.m. **Welcome**
Erika Clark Jones, Co-chair, CEO, ADAMH Board of Franklin County
Jeff Klingler, Co-chair, President and CEO, Central Ohio Hospital Council

3:10 p.m. **Roll Call** (Name and organization in chat)

3:15 p.m. **Transition of SC &Workgroups to PCES Joint Meetings**
Annie Gallagher, Gallagher Consulting Group
Future involvement survey link: https://www.surveymonkey.com/r/N27DHSF

3:30 p.m. **Workgroup Reports**

- **Building Design**
  Mark Hunter, Franklin County Public Facilities Management & Mike MacKay, OhioHealth
- **Governance / Funding**
  Erika Clark Jones, ADAMH & Jeff Klingler, Central Ohio Hospital Council
- **Consumer Care**
  Dr. Delaney Smith, ADAMH & Katrina Kerns, North Community Counseling
- **Data / Technology**
  Jonathan Thomas, ADAMH & Andy Dorr, OSU Wexner Medical Center
- **Community Access**
  Dr. Kevin Dixon, ADAMH & Kenton Beachy, Mental Health America

4:45 p.m. **Summary and key next steps**
Jonathan Thomas, Project Lead, VP Planning and Evaluation, ADAMH

Next PCES Meeting – March 30th 10:00 am – 11:30 am Virtual

5:00 p.m. **Adjourn**

ADAMH
Alcohol, Drug and Mental Health Board of Franklin County

Franklin County Mental Health and Addiction Crisis Steering Committee

Conclusion & Transition

January 28, 2021

Where we started
Background

- Psychiatric Crisis & Emergency System Task Force of Central Ohio (PCES)
- Funding partners

The Columbus Foundation · ADAMH Alcohol, Drug and Mental Health Board of Franklin County · Central Ohio Hospital Council · Osteopathic Heritage Foundations · The City of Columbus, Andrew J. Ginther, Mayor

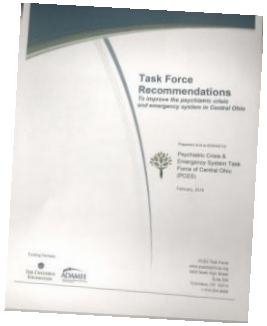
- Leadership

  ADAMH, The Columbus Foundation, Columbus Medical Association + Affiliates, Central Ohio Hospital Council

- Goals

  1. Increase access to patient-centered mental health and addiction-related crisis services and expand intermediate and ambulatory care options.
  2. Decrease utilization of emergency departments and inpatient services and reduce the length of stay of psychiatric patients in emergency rooms.
  3. Ensure equitable patient care regardless of payor source.

Where we started
Background



- Recommendations from PCES Task Force
  - Need to ***increase access*** to crisis care for everyone in Franklin County
  - Need to ***improve the overall quality*** of crisis care in Franklin County
  - Need to meet Franklin County's current and ***future demand*** for crisis care
  - Recommendation to ***provide a central core facility to serve as a preferred destination*** for crisis needs in Franklin County

- Completed feasibility study of regional psychiatric emergency facility

  (Dec 2016) BATTELLE

- Implementation via FCMHACC Steering Committee and its strategic workgroups

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Where we are
FCMHACC Steering Committee

March 2019 – January 2021

Activities:

Steering Committee Meetings / Retreats / Site Visits to CXNS / Work Groups

NAMI Franklin County

The City of Columbus — Andrew J. Ginther, Mayor — Columbus Public Health

OhioHealth

the PEER center — Peers Enriching Each others' Recovery

Franklin County Public Health

NetCare Access

Mount Carmel

The Ohio State University Wexner Medical Center

Osteopathic Heritage Foundations

Columbus Division of Fire

MaryHaven — Helping People Restore Their Lives

Columbus Police

MHA Mental Health America of Franklin County

Franklin County Ohio

The Columbus Foundation

north Community Counseling centers inc

North Central Mental Health Services

The City of Columbus — Andrew J. Ginther, Mayor

Franklin County Sheriff's Office

ADAMH — Alcohol, Drug and Mental Health Board of Franklin County

Where we are

Committee & work groups complete scope

Erika Clark Jones
Co-chair
CEO, ADAMH

Jeff Klingler
Co-chair
CEO, COHC

Jonathan Thomas
Project Lead
VP, Planning & Evaluation

Work Groups

Building Design
Started July 2019

Governance & Funding
Started June 2019

Community Access
Started April 2020

Consumer Care
Started July 2019

Data & Technology
Started June 2019

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Where we are going

Transition and next steps

Today: January 28, 2021

- Last Steering Committee meeting
- Final work group reports and recommendations
- Summary report of all work group and Steering Committee findings and recommendations will be developed

Next Steps: The Work Continues

- Community stakeholder quarterly meetings will continue via PCES at The Columbus Foundation. FCMHACC Steering Committee and work group members encouraged to participate.
- FCMHACC final report and recommendations will be shared with ADAMH Board and new center governance entities
- Pending work group activities and tasks will be shifted to ADAMH and center leaders

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We still need YOU!

Please let us know how you would like to continue to contribute your talent and knowledge to make the crisis center a success:

Online survey: https://www.surveymonkey.com/r/N27DHSF

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Strategic Governance for the Franklin County Mental Health and Addiction Crisis Center

Recommendation developed by the

FCMHACC Governance and Funding Workgroup

The FCMHACC Governance and Funding Workgroup recommends the development of a strategic governance body, referred to in this document as the "Crisis Center Advisory Council," to ensure that the Crisis Center meets the expectations identified by community stakeholders. The role of the Advisory Council is to hold the vision, mission, and values for the system in which the crisis provider will operate, define outcomes that support the system's goals, manage the expectation of the operator(s) for meeting defined outcomes, and facilitate ongoing system improvement.

In addition, the workgroup feels it is the role of the Advisory Council to articulate the goals of the Crisis Center, identify strategies to meet stated goals, review outcome metrics, identify opportunities for improvement, and solve problems. A draft of goals, strategies and metrics identified by the workgroup is attached to this document.

Advisory Council Representation

The Advisory Council will be comprised of representatives for the following organizations:

- City of Columbus (representative of Public Safety)
- Franklin County (representative of the Commissioners)
- Hospital systems (one representative)
- Community Mental Health Centers (one representative)
- ADAMH Board of Franklin County
- Two representatives identified by the Consumer & Family Advocacy Council (C&FAC), representing consumers, families and peers
- Operator of the Crisis Center (one representative)
    - While there may be multiple operators within the Crisis Center, it is expected that ADAMH will contract with a single entity to operate the center. This entity will be represented on the Steering Committee. If ADAMH contracts with multiple operators, representation should be revisited
- Ex-officio representative from ad hoc payor committee (see below)

Representatives serving on the Advisory Council should be senior leaders within their respective organizations and should have general decision-making authority. Members also should be "thought leaders," or individuals with innovative ideas who can turn informed opinions into reality.

Ad Hoc Payor Committee

The Advisory Council will consider the establishment of an Ad Hoc Payor Committee, comprised of representatives from stakeholders not represented on the Advisory Council. Possible representation on the committee could include, but would not be limited to, Medicaid managed care organizations, state Medicaid, and Ohio Mental Health and Addiction Services. A representative from the Ad Hoc Payor Committee would provide feedback to the Advisory Council via an ex officio representative to the Advisory Council.

Relationship between the Advisory Council and the Operator

It is expected that ADAMH will contract with a single entity to operate the Crisis Center. It is also expected that this single entity will establish a body to oversee the management, finances, quality and strategic direction of the Crisis Center, either through a Board of Directors or other internal mechanism. The Advisory Council will establish clear performance metrics and identify and provide ongoing review of the expectations of the Crisis Center operator(s). The Advisory Council's expectations and ongoing review will be shared through ongoing communication with the operator and the operator's governing board/internal mechanism. To facilitate this communication, it is recommended that the Crisis Center operator have a representative serve on the Advisory Council and a representative of the Advisory Council have access to and the ability to communicate directly with the Operator's Governing Board/internal mechanism. Accountability for meeting performance metrics will be managed through contractual structures to be established by the Franklin County ADAMH Board.

Organizational Relationships Visual (attached)

A visual has been be created, showing the relationship between:

- The ADAMH Board and:
    - The Crisis Center Operator(s)
    - The Advisory Council
    - The Ad Hoc Payor Committee
- The Advisory Council and the Operator(s)
- The Advisory Council and community stakeholders
- The Advisory Council and the Ad Hoc Payor Committee

Recommended Goals and Strategies for the Franklin County Mental Health and Addiction Crisis Center

Draft recommended by the FCMHACC Governance and Funding Workgroup

Oct. 21, 2020

Goals	Strategies	*As measured by*	NOTES
Increase access to mental health and addiction crisis care	Center is accessible to anyone age 18+ in Franklin County at the time of their crisis (regardless of residency or insurance status)		
	Center is accessible 24/7, 365 days a year	*Hours center is closed from walk-ins and LE/EMS drop=off*	Expectation is zero hours
	No exclusions for behavioral acuity		Note the importance of patient-centered, trauma informed care, not just restraint and medication
	Rapid drop-off for first responders (EMS and police)	*Time from arrival to departure of LE/EMS*	Source: EHR event? Possible LE/EMS data to validate?
	No refusal for law enforcement, EMS or mobile crisis teams for appropriate transports	*Hours on divert for LE/EMS drop-offs*	Transport protocols being recommended by Consumer Care WG
	Center accept both voluntary and involuntary patients (including probates)	*Admissions by status (voluntary vs involuntary [and within this: probate vs other]) and among those presenting involuntarily, percent who convert to voluntary receipt of services*	source: EHR? Note that many who start out as voluntary can become involuntary over time, and vice versa. This may impact measurement.
	Center treats substance abuse and mental health issues	*Presentations by primary diagnostic grouping (AOD diagnoses only, MH diagnoses only, and dual diagnosis)*	Demographics and trends of substance; source: EHR

Improve quality of crisis care by offering a spectrum of mental health and addiction services	System provides enhanced services pre Crisis (e.g. Call Center, Mobile Response)	Call center volume and stats, mobile crisis runs, ROW transports	If multiple operators within the Center, clarify the role of the Advisory Council on strategic oversight of crisis continuum vs. crisis center operator only (recommendation is continuum)
	Center facilitates 'warm handoffs' to community-based programs after crisis care is provided	*Percent of individuals who receive a follow-up assessment/community provider service within seven days oh discharge from Center* *Percent of individuals accessing services same-day as need is identified (OR Average days to first follow-up service)* *Percent of individuals who are engaged by community provider prior to discharge from Center (the "warm hand-off")*	
	Manage readmissions to the center (or other facility) within (30 days/72 hours?)	*Percent of discharges that are followed by a readmission within (30 days/72 hours?)* *Netcare mobile crisis data*	Would need coordination between EHRs of different facilities Dependent upon buy-in from MCP payors and the homeless population served Is there a threshold/benchmark or any comparison data? Possibly different benchmarks per level of care in Center
	Center receives and provides patient and aggregate data/feedback loops to the broader continuum of care		Need for public/community dashboard, scorecard (display some of the metrics in this sheet)
	Fewer people with active behavioral health needs are transported to jails	*Percent of mental health-related CPD calls for service that result in a transport to Franklin County Jail*	Source: CPD monthly report of MH calls for service
	Fewer people with active behavioral health needs are transported to emergency departments	*Number of people redirected from EDs to Center*	
	Medical services provided, reducing need for ED transports	*Number of transfers out of Center for medical services*	Source: EHR

Establish a financially sustainable business model to assure immediate and ongoing/future success	Negotiate viable contracts with all applicable payers including, but not limited to, Medicaid, Medicare, and commercial insurance.	*Percentage of gross charges by payer*	Ex: Commercial 5% Medicaid (includes FFS and MCO) 65% Medicare (includes Medi-Medi) 15% Uninsured (includes covered by ADAMH) 15%
	Implement strategies to maximize cost containment	*Average hourly rate for each occupation category is within accepted percentile range compared to industry benchmarks*	Salaries and benefits are indexed to industry benchmarks; need access to BH workforce benchmarking resources
	Ensure appropriate bidding of contracted services	*Variance from target baseline for contracted services*	We can model a target baseline from data solicited from partners regarding their services.
	Maximize cost savings from diversions from ED presentations/inpatient admissions	*Estimated cost savings from utilization of Center and preventing ED presentations/inpatient admissions*	Source: Estimate of cost differential and magnitude of change in ED presentations/IP admissions?
	Develop strategies to minimize subsidies for ongoing operations of the Center		
	Maximize Medicaid coverage of patients treated at the Center, including ability to grant presumptive eligibility	*Percent of individuals who are Medicaid enrolled and percent of individuals presenting who are converted to Medicaid enrollment*	Source: EHR?
	Monitor and manage provider productivity	*Average paid hours per visit*	This is an area that would benefit from a consultant providing a validation of an operators staffing model. We could apply a general assumption that each provider needs to generate a certain percent to be financially sustainable and we could benefit from a consultant company that does management engineering and process improvement to provide guidance.
	Maximizing service claims that are accepted and paid by payers	*Productive time per work hours* *Percent of claims that are denied*	
	Develop strategies on patient throughput, allowing for the efficient flow of patients through the Crisis Center	*Percent of patients from the Center with indicated need accepted by inpatient providers*	"Hospital holds" -CXNS

Establish a workplace culture that attracts, retains, and develops a workforce/talent to provide optimal care for patients.	Develop strategies that improve employee wellness and reduce employee burnout	*Staff retention and turnover rates are inline with industry benchmarks*
		Percent of employees who vacate positions within first year of employment *Leave usage rates (or other method of measuring burnout)*
	Center provides ongoing teaching and training opportunities that promote employee development, success and career advancement	
	Center provides benefits that promote a positive work/life balance	
	Patient satisfaction and associate engagement	
	Center incorporates diversity and inclusion strategies that ensure its workforce is reflective of the community it serves, including gender, race and ethnicity, sexual orientation/gender identity. Recruitment of staff that is reflective of community demographics	

Commit to and measure health outcomes that improve the overall health of the broader community.	Center develops and publishes a dashboard showing broader community mental health indicators along with comparative benchmarks (i.e. Healthy People goals)	*Number of overdose deaths and age-adjusted rate of overdose deaths within community*	Source: ODH Vital Stats (Public Health Information Warehouse)
		Number of suicide deaths and age-adjusted rate of suicide deaths within community	Source: ODH Vital Stats (Public Health Information Warehouse)
		Number of CPD calls for domestic violence and child and elder abuse	
		Percent of population experiencing a major depressive episode	Source: National Survey on Drug Use and Health, substate estimates
	Center incorporates recognized best practices for opitmal health outcomes for its patients	*Percent of patients successfully connected to primary care*	
		Social determinants of health metrics (% of patients with insurance, % of patients with stable housing, % of patients with food insecurity, % of patients employed)	Stable housing requires a more specific definition

Adhere to best safety practices, including those required through licensure, certification, and accreditation.	Develop strategies that promote optimal patient safety and reduce preventable patient harm	*Number of major unusual incidents (restraints/seclusion) and percent of patients who are restrained/secluded*	Some HEDIS/HBIPS measures that align Source: EHR
		Number of elopements	
		Use of involuntary medications	
	Develop strategies that promote optimal employee safety and reduce preventable employee harm	*Incidence of workplace injuires*	
		Incidence of workplace violence	
	Provide staff training opportunities on updated interventions around patient and employee safety (e.g., Trauma Informed Care, SMART tool for medical clearance [to monitor invasiveness of testing], Zero Suicide)	*Percent of staff who undergo training in identified best practices/promising practices/evidence-based models*	
	Incorporate intelligent design of physical plant to promote patient and employee safety		

FCMHACC Strategic Governance Relationships

ADAMH Board of Franklin County

Contract

Organizes

Advises

Organizes

FCMHACC Operator

- Operator may subcontract services, as allowed by contract
- Operator accountable to ADAMH; subcontractors accountable to operator

Community Advisory Council

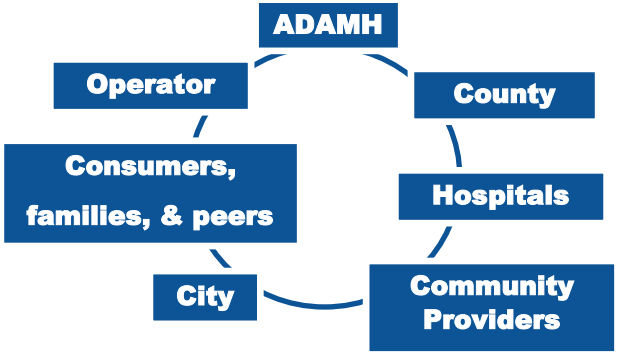
- Establishes performance metrics and identifies and provides ongoing review of FCMHACC expectations
- Provides guidance to ADAMH and to operator

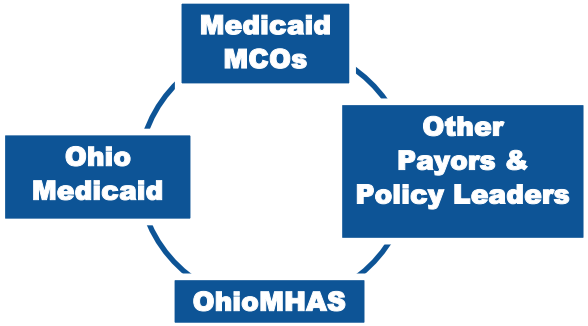
Ad-hoc Payor Committee

- Provides feedback to the Advisory Council via an ex officio representative to the Advisory Council

Blue, solid line arrows represent formal relationship with accountabilities.

Purple, dotted line arrows represent informal relationships that are advisory in nature.





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Alcohol, Drug and Mental Health Board of Franklin County

Franklin County Mental Health and Addiction Crisis Center

Workgroup Presentation

December 9, 2020

Updated FCMHACC Volume Estimates (from Consumer Care & Data/Technology)

- Updated December 2020
  - Year 1 = 28,172
  - Year 10 = 34,551

- Estimated impacts
  - 90-100% of Netcare's current volume will be served by new FCMHACC
  - 55-65% of EMS transports will be served by new FCMHACC (***NOTE: currently 0%***)
  - 80-90% of Police transports will be served by new FCMHACC (***NOTE: currently < 40%***)
  - 75-110 probate consumers per month will be served by the new FCMHACC

- Estimates represent the new FCMHACC accounting for 60-70% of current ED volumes

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FCMHACC Proforma Assumptions (from Governance/Funding)

- Revenue Assumptions
  - Revenue per encounter estimates from HMA/HCP revised by Steering Committee
  - Payment rates are based on 2019 Medicaid Behavioral Health (BH) codes
  - ADAMH pays Medicaid BH rates for uninsured patient population

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FCMHACC Proforma Assumptions (from Governance/Funding)

- Expense Assumptions
  - Direct Patient Care Labor wages based on high end of Blue & Co. LLC 2018 Compensation & Benefit Survey
  - Direct Patient Care Labor staffing models based on Crisis Now recommendations
    - Operator's planned staffing ratios will be a part of RFP
  - Indirect Administrative Costs are 12% of operating revenue from Steering Committee members
  - Facility Operating Costs also based on actuals cost per sq. ft. from Steering Committee members
    - Owner's rep will provide a proforma on facility operating costs as part of RFQ
  - Assumes 3% inflation rate on Direct Patient Care Labor, Non-Labor Costs, & Indirect Costs

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Preliminary FCMHACC Proforma – Current Medicaid FFS

	Qualified Entity for PE		Non-Qualified Entity for PE	
	Avg. Annual P&L	5 Year Total	Avg. Annual P&L	5 Year Total
Operating Revenue	$ 14,870,509	$ 74,352,546	$ 9,971,989	$ 49,859,943
Uninsured Funded By ADAMH	$ 2,624,208	$ 13,121,038	$ 7,522,728	$ 37,613,641
Total Operating Revenue	**$ 17,494,717**	**$ 87,473,584**	**$ 17,494,717**	**$ 87,473,584**
Direct Patient Care Costs	$ 21,529,073	$ 107,645,367	$ 21,529,073	$ 107,645,367
Indirect Administrative Costs	$ 2,152,226	$ 10,761,129	$ 2,152,226	$ 10,761,129
Facility Operating Costs	$ 1,261,363	$ 6,306,815	$ 1,261,363	$ 6,306,815
Capital / Replacement Equipment	$ 364,775	$ 1,823,873	$ 364,775	$ 1,823,873
Total Operating Expenses	**$ 25,307,437**	**$ 126,537,184**	**$ 25,307,437**	**$ 126,537,184**
Total Operating Profit/(Loss)	**$ (7,812,720)**	**$ (39,063,600)**	**$ (7,812,720)**	**$ (39,063,600)**

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Preliminary FCMHACC Proforma – Current Crisis Per Diem Pilots

	Qualified Entity for PE		Non-Qualified Entity for PE	
	Avg. Annual P&L	5 Year Total	Avg. Annual P&L	5 Year Total
Operating Revenue	$ 26,917,761	$ 134,588,803	$ 18,050,734	$ 90,253,668
Uninsured Funded By ADAMH	$ 4,750,193	$ 23,750,965	$ 13,617,220	$ 68,086,100
Total Operating Revenue	**$ 31,667,954**	**$ 158,339,768**	**$ 31,667,954**	**$ 158,339,768**
Direct Patient Care Costs	$ 21,529,073	$ 107,645,367	$ 21,529,073	$ 107,645,367
Indirect Administrative Costs	$ 3,895,389	$ 19,476,946	$ 3,895,389	$ 19,476,946
Facility Operating Costs	$ 1,261,363	$ 6,306,815	$ 1,261,363	$ 6,306,815
Capital / Replacement Equipment	$ 364,775	$ 1,823,873	$ 364,775	$ 1,823,873
Total Operating Expenses	**$ 27,050,600**	**$ 135,253,002**	**$ 27,050,600**	**$ 135,253,002**
Total Operating Profit/(Loss)	**$ 4,617,353**	**$ 23,086,767**	**$ 4,617,353**	**$ 23,086,767**

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FCMHACC Medicaid Revenue Enhancements & Considerations

- Revenue Enhancement Opportunities
  - Fee For Service Modifications
    - Peer support reimbursement for mental health primary diagnosis
    - Observation reimbursement
  - Per Diem Pilots
    - Medicaid Managed Care & ADAMH have started similar reimbursement methodology

- Other Financial Considerations
  - Qualified Entity status improves payer mix
  - Reimbursement for ambulance transportation to FCMHACC
    - Transports to Netcare not currently reimbursed by Medicaid and community EMS would experience reimbursement decline by redirection away from hospital EDs

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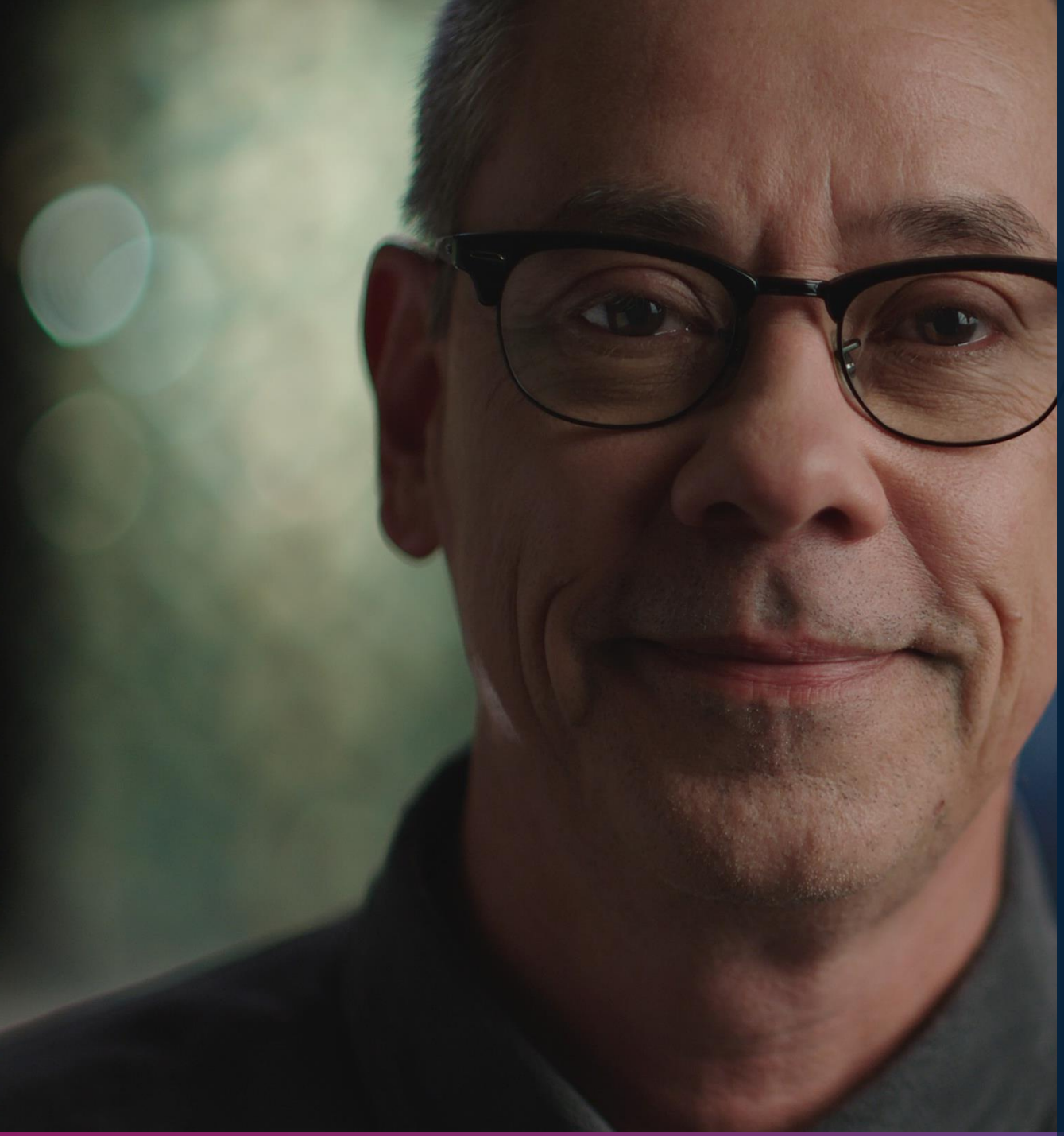

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Thank You

fcmhacc.com

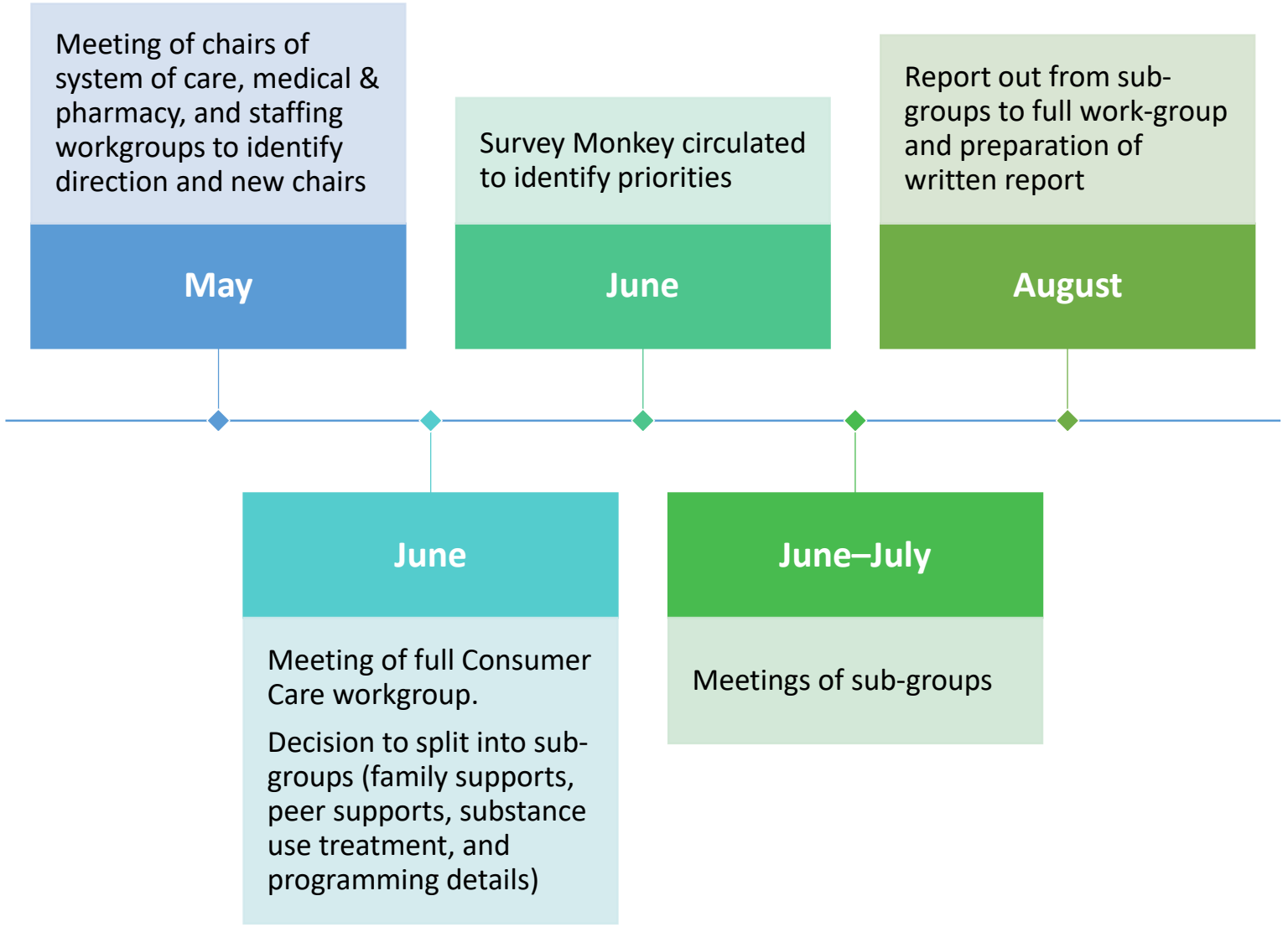
Consumer Care

Co-Chairs: Katrina Kerns & Delaney Smith

Charge

- Provide recommendations about services in the new crisis center

Process


Meeting of chairs of system of care, medical & pharmacy, and staffing workgroups to identify direction and new chairs
May
Survey Monkey circulated to identify priorities
June
Report out from sub-groups to full work-group and preparation of written report
August
June
Meeting of full Consumer Care workgroup.
Decision to split into sub-groups (family supports, peer supports, substance use treatment, and programming details)
June–July
Meetings of sub-groups

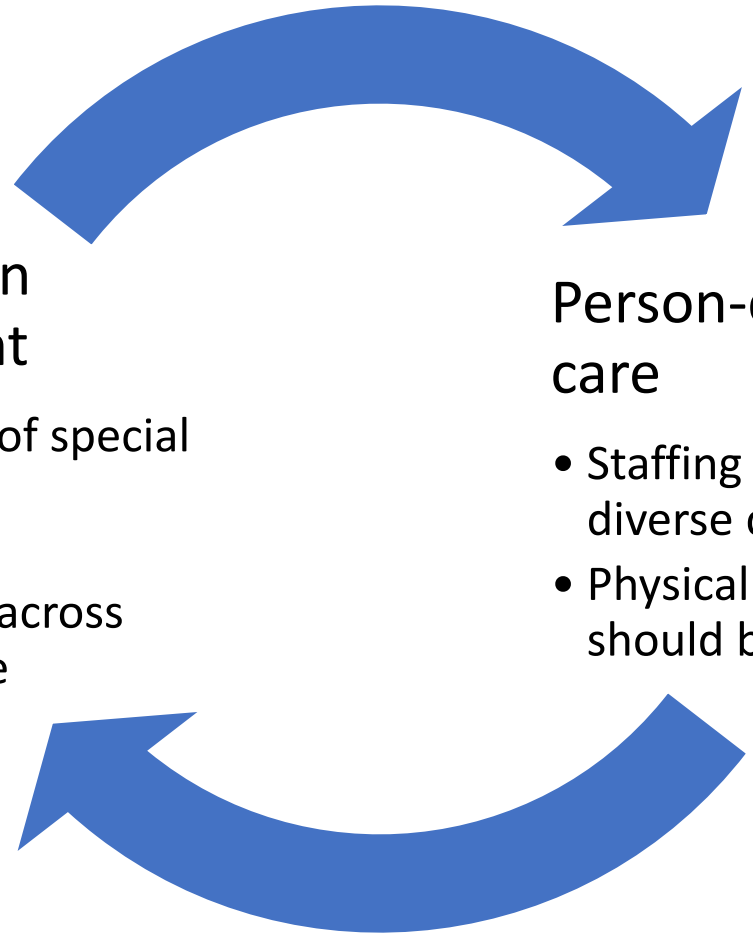
Family Support Sub-group

Emphasis on engagement

- Recognition of special populations
- Hand-off of information across levels of care

Person-centered care

- Staffing to reflect the diverse community
- Physical environment should be adaptable

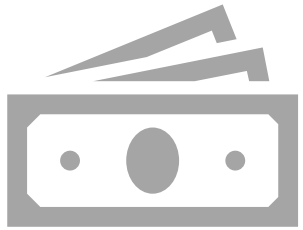


Peer Support Sub-group

Integration into all aspects of treatment

Peer is first to meet guest and acts as a guide

Peers should be part of each stage of treatment



Address barriers to peer work-force

Challenging certification process

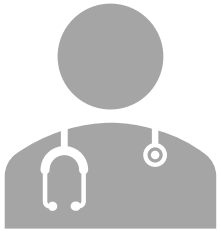
Medicaid reimbursement issues

Competitive pay and benefit packages

Supervisor designation challenges

Legal history

Substance Use Treatment Sub-group



Scope of detoxification services

Ability to manage most presentations of intoxication or withdrawal with supportive medications and safe environment

Medication Substance Use Disorders

Provide small bridge amounts of medication

Ability to schedule same or next day appointments

Programming Details Sub-group

- Crisis Hotline (pre-crisis center)
  - Work closely with mobile and new crisis center, but not needed to be co-located or operated by same vendor
    - Need single hub for crisis response
    - Access to real time appointment scheduling

Programming Details Sub-group

- Mobile Response Team (pre-crisis center)
  - Strong collaboration with crisis hotline and new crisis center, but not needed to be co-located or operated by same vendor
    - Consider movement toward clinician driven teams
      - Social workers, peers, nurses
    - Ability to schedule timely follow up appointments

Programming Details Sub-group

Intake/Assessment/Triage

Brief lobby assessment to determine needed level of care

Screen for communicable diseases

Walk-in/Bridge Clinic

Emphasis on engagement with community mental health providers

On-site providers and telehealth available

Bridge guests who need follow-up after stays in 23-hour or 24+ hour units until can see their provider

Programming Details Sub-group

- 23-hour Observation Unit
  - Hybrid living room/recliner model
    - Space can be split for milieu needs
  - Separate interview rooms
  - Individual rooms for high need guests (psychosis, intoxication/withdrawal, and medical conditions)

Programming Details Sub-group

- 24+ hour unit(s):
  - Consider splitting 16 beds into 2 units
    - Crisis Stabilization
      - Franklin Count now only has 10 CSU beds
      - Unique level of care that emphasizes guest engagement and skill building
    - Inpatient beds

Programming Details Sub-group

Medical Support Services

24/7 on-site provider of urgent-care level of services

Pharmacy Services

Full pharmacy support for 23-hour and 24+ hour units

Ability to provide small take-home supply

FCMHACC Volume Estimates

Updated Volume Estimates

- Started with 2019 volume estimates from Data / Technology Workgroup
- Reduced primary volume assumption 5% to partially account for anticipated impact of crisis call center and mobile response
- Stratified volume estimate based on acuity
    - 5% of current demand from transports resolved in the 24/7 clinic
    - 10% of current demand from walk-ins resolved in the 24/7 clinic
- Added a 1-for ever-3 assumption of new demand/volume for the 24/7 clinic

Year 1 (total volume/unique encounters)

28,172

Year 10 (total volume/unique encounters)

34,651 (down from 37,333)

- 24/7 clinic volume = 10,188 encounters
- 23-hour observation volume = 24,463 encounters with 15-hour avg. LOS
- Crisis Stabilization Unit (10 beds) volume = 1,217 with 3-day avg. LOS
- Inpatient Unit (6 beds) volume = 438 with 5-day avg. LOS

Franklin County Mental Health and Addiction Crisis Center

Communications and Engagement Plan

December 2020

Background or Situational Analysis

Roughly 21 percent of Franklin County's 1.3 million residents will experience mental illness in a given year, and another 10 percent will abuse or be dependent on drugs or alcohol. The number of Franklin County residents is expected to grow by 8 percent over the next 10 years. During that same period, we anticipate a 23 percent increase in for mental health and substance abuse disorder services

Currently, nearly 70 percent of all crisis encounters related to mental health and addiction are currently treated in hospital emergency departments despite evidence outcomes are better when services are provided in a community-based setting. As part of a commitment to improving the continuum of crisis care in our community, the Alcohol, Drug and Mental Health Board of Franklin County (ADAMH) is partnering with the Central Ohio Hospital Council and other community stakeholders to plan and construct a comprehensive center intended to support adults in Franklin County experiencing (or at risk of experiencing) a crisis associated with their mental health and/or substance use disorder.

The new Franklin County Mental Health and Addiction Crisis Center will be the central and primary destination in Franklin County for mental health and addiction crisis needs and will offer a no-wrong-door-philosophy to ensure that anyone who arrives at the center receives services

A communications strategy is needed to support engagement of key stakeholders throughout the funding, construction and opening of this new facility in order to garner financial support, educate the entire community on the benefits and encourage individuals to seek out the center even before they find themselves in crisis.

Key Audiences

- Elected officials
- Community leaders
- Hospital systems
- First responders
- Behavioral health providers
- Peer support specialists
- Primary healthcare providers in underserved communities

- Community associations near proposed site
- Corporate and foundation funders
- Business community
- New Americans communities
- Faith community leaders
- Residents in neighborhoods near the center
- Prospective patients and their families
- General community

Challenges and Underlying Assumptions

- Communities near the proposed site of the new crisis may be wary of a crisis facility near their neighborhood.
- Many of the individuals who may benefit from the center are hard to reach through traditional communication channels and language and cultural barriers must be identified and managed to in all outreach and communications.
- There is a long lead time until the crisis center opens its doors, making it critical to identify points along the way to create energy, provide information and highlight progress being made in construction.
- Community-wide collaboration must continue throughout the funding, construction and opening of the center and must inform outreach strategies.
- Lack of clarity of the role the operator will have in community and patient communications prior to grand opening and the anticipation that the operator will be the primary communicator for the Center after opening.
- ADAMH has not yet allocated funding to support marketing and communication needs for launching the Center.

Timing

January 2021 through the grand opening of the new Crisis Center in 2023.

Key Messages

1. The need for mental health and substance use crisis care continues to grow in Franklin County.
    - Roughly 21 percent of Franklin County's 1.3 million residents will experience mental illness in a given year, and another 10 percent will abuse or be dependent on drugs or alcohol.
    - The number of Franklin County residents is expected to grow by 8 percent over the next 10 years. During that same period, we anticipate a 23 percent increase in for mental health and substance abuse disorder services over the next 10 years.

- Almost 30,000 mental health crisis episodes are treated in Franklin County annually. The vast majority of these episodes are addressed in hospital emergency departments instead of a clinically appropriate crisis center.
- Approximately 70 percent of all crisis encounters related to mental health and addiction are currently treated in hospital emergency departments despite evidence outcomes are better when services are provided in a community-based setting

2. ADAMH and its partners are committed to improving crisis care in Franklin County and a cornerstone of that commitment is the development of a centrally located crisis care center where services are available in one place.
   - The center will serve adults age 18 and over who are experiencing a mental health or addiction-related crisis.
   - The center will be open 24 hours a day, seven days a week and include a public walk-in entrance and an entrance for first responders.
   - The estimated patient volume in year one is 30,000 encounters.
   - ADAMH owns a parcel of land on Harmon Avenue in the West Edge area, which had been evaluated and determined viable for the new Crisis Center.
   - Construction is anticipated to begin in Fall 2021 and is targeted for opening in 2023.

3. Improved behavioral health crisis care benefits everyone – from the person in crisis and their family to first responders and hospital systems.
   - Patients will have access to a full array of clinic services, including walk-in clinic services for those not yet in crisis.
   - The Crisis Center will have capacity to meet community needs and is viewed by law enforcement as the preferred facility for individuals in need of emergency crisis care.
   - The Crisis Center is viewed by first responders as the preferred facility for individuals in need of emergency psychiatric and crisis care.
   - Patients with both mental health and substance use disorders will receive coordinated care at the Crisis Center.
   - Patients with coexisting medical issues will be evaluated and treated at the Crisis Center, eliminating the need to transport patients to emergency departments.
   - Patients will be safely secured at the Crisis Center.
   - Patients will be linked to services and follow-up care before being discharged.
   - Families will be provided with education and tools to help their loved one succeed after discharge from the Center.

4. This new crisis center is a community-wide project and a community-wide investment.
    - Voices from every part of the community are being included in the center's development, including community providers, hospitals, law enforcement, advocacy organizations, Mental Health American and NAMI Franklin County.
    - Most importantly, we are listening to the voices of people who use the behavioral health system and their families.
    - Funding for the estimated $50 million in construction costs is coming from public and private commitments:
        - As of December 2020, the following commitments have been made to support capital costs:
            - $8 million – ADAMH
            - $8 million – Adult service hospitals (OSU Wexner Medical Center, Mount Carmel, OhioHealth)
            - $10 million – City of Columbus
            - $10 million – Franklin County Commissioners

Communication Strategies

1. Generate ongoing support for the new Crisis Center through ongoing education and communications highlighting the benefits the new center will bring to Franklin County.
2. Mitigate any potential criticism or concerns in the community by maintaining transparency in all matters relating the Crisis Center planning, location, construction, funding and operations.
3. Leverage the development of the crisis center as a way to lead the conversation on strategies to continually improve the continuum of crisis care in Franklin County.
4. Establish the new Center a first-choice crisis resource throughout the community and the primary destination for individuals and families during and before they experience a behavioral health crisis.

Communication Tactics

Strategy #1: Generate ongoing support for the new Crisis Center through ongoing education and communications highlighting the benefits the new center will bring to Franklin County and leveraging key points in the timeline to show progress.

Tactics

- Revise collateral materials to assist with engaging with community and securing additional funding
    - Overarching branding as an ADAMH project
    - Fact sheet

    - PowerPoint
    - E-newsletter with monthly updates
        - Develop strategy for growing newsletter distribution list (will be needed for other tactics like grand opening events)
    - Enhance website content (timeline, construction cam, information translated into other languages as needed)
- Develop and train speakers' bureau, with diverse partners to speak to community groups
- Identify groups to speak to and schedule speakers
- Develop a list of key stakeholders, their contact information and who "owns" that relationship
- Highlight key milestones on the Crisis Center timeline as opportunities for media coverage, social media posts, e-newsletter updates, presentations before key stakeholder groups:
    - Operator selection
    - Site selection confirmation
    - Architectural plans unveiled
    - Hitting fundraising goal – announcing all funders, named spaces, etc.
    - Naming the entire Center in honor/memory of an important leader in this space
- Hold a major groundbreaking event to garner media coverage and bring partners together
- Media, VIP and key stakeholder tours at key points during construction
- Beam signing with all the partners for the last beam/topping off ceremony
- Grand opening week with multiple touchpoints for key stakeholders, multiple opportunities for media coverage:
    - Ribbon cutting event
    - Provider tours
    - First responder tours
    - Community tours
    - Media Tours
    - Welcome signage in various languages

<u>Strategy #2</u>:

Mitigate any potential criticism or concerns in the community by maintaining transparency in all matters relating the Crisis Center planning, location, construction, funding, and operations.

Tactics:

- Enhance website as the central repository of all public documents, announcements, and updates

- Develop, regularly update a Q& A to house on the website
- Identify, confirm Crisis Center spokespeople: Erika Clark Jones, Jonathan Thomas, Jeff Klingler
- Meet with Westside community groups on regular intervals to keep the abreast of the center's construction, timeline for opening.
- Regularly meet with key government partners at the city and county levels.
- Secure third-party advocates who will talk with the community groups and media to provide support the for center; provide them with regularly updated talking points and other information on Center.

Strategy #3:

Leverage the development of the crisis center as a way to lead the conversation on strategies to continually improve the continuum of crisis care in Franklin County.

Tactics:

- Clearly brand the new Crisis Center as an ADAMH project.
- Integrate advocacy for improving the continuum of crisis care into the overall ADAMH thought leadership strategy with major elements to include:
    - Metropolitan Club program – panel discussion ADAMH and key partners
    - Columbus Chamber of Commerce
    - Dispatch editorial board
    - All Sides with Ann Fisher
    - Op-ed placements
    - Radio PA shows
    - Host community forum(s)
    - Outreach to elected officials

5. Strategy #4: Establish the new Center a first-choice crisis resource throughout the community and the primary destination for individuals and families during and before they experience a behavioral health crisis.

Tactics (in partnership with Center operator):

- Conduct focus group research to guide communications with target audiences.

- Create a network of trusted friends and advisors including faith leaders, non-profit leaders, peers, etc. who can serve as educators and advocates for directing those in need of crisis intervention to the center. Schedule regular update calls and meetings, and provide them with leave-behind information.
- Develop culturally-appropriate collateral materials explaining what the center is, benefits of using it, how to access care through postcard mailers, brochures, other leave behinds – translated as needed.
- Develop a virtual tour of the Crisis Center that can be leveraged on multiple platforms to help familiarize the community with the facility.
- Develop a targeted social media campaign.
- Outreach to area hospital systems – provide collateral materials for EDs.
- Outreach to primary healthcare centers/doctors in targeted zip codes – provide collateral materials they can use with patients/families.
- Literature drops in targeted communities.
- Place stories in diverse print media; secure radio interviews on stations reaching diverse audiences.

Paid media plan – combination of digital and print (budget needed, estimate: $50k)

Measures of Success:

- Develop a dashboard that includes:
    - Number of touches, hitting targeted communities
    - Social media metrics
    - Achieving fundraising goal
    - Earned media placements
    - Hitting timelines

Crisis Center Communications Major Milestone Timeline – Tentative –will be guided by overall planning process

Timeframe	Tactic	Responsible	Notes
Q1 2021	Revise collateral materials – rebranding an ADAMH initiative	Leah Hooks	Includes fact sheets, PPT, e-newsletter
Q1 2021	Begin work enhancing website	Leah Hooks	This will be ongoing
Q1 2021	Compile key stakeholder lists	Shelly Hoffman/Mackenzie Betts	Working with community outreach subcommittee
Q1 2021	Funding commitment secured	Shelly Hoffman	
Q2 2021	Develop plan for community outreach/engagement	Shelly Hoffman/Mackenzie Betts	
Q2 2021	Operator selection announcement	Shelly Hoffman/Mackenzie Betts	
Q2/3 2021	Site selection confirmation/announcement	Shelly Hoffman/Mackenzie Betts	
Q3 2021	Architectural firm selection	Shelly Hoffman/Mackenzie Betts	
Q43&4 2021	Development of speakers' bureau	Diane Peterson	
Q4 2021	Architectural design unveiled	Shelly Hoffman/Mackenzie Betts	
Q4 2021	Groundbreaking	PA Team	
2022	Beam signing/topping off ceremony	PA Team	
2022	Conduct focus group research to guide communications with target audience	PA Team	Will need to bring on outside resource
2022	Construction tours	TBD	Dependent on construction tours
2022	Development of a virtual tour	PA Team	In conjunction with architect, need budget
2022	Step up speakers' bureau deployment	Diane Peterson	
2023	Launch comprehensive strategy for grand opening	Shelly Hoffman	Role of operator?

ADAMH

Alcohol, Drug and Mental Health Board of Franklin County

Franklin County Mental Health and Addiction Crisis Center

Communications and Engagement Plan Update
Jan. 28, 2021

Communications and Engagement Plan

Goal:

To support engagement of key stakeholders throughout the funding, construction and opening of this new facility in order to garner financial support, educate the entire community on the benefits and encourage individuals to seek out the center even before they find themselves in crisis.

Timing:

January 2021 through the grand opening of the new Crisis Center in 2023.

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Alcohol, Drug and Mental Health Board of Franklin County

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Measures of Success

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- Number of touches, reaching targeted communities
- Social media metrics
- Achieving fundraising goal
- Earned media placements
- Meeting timelines

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Crisis Center Summary Timeline

	2021-Q1	2021-Q2	2021-Q3	2021-Q4	2022-Q1	2022-Q2	2022-Q3	2022-Q4	2023-Q1	2023-Q2	2023-Q3	2023-Q4	2024-Q1
Steering Committee Close-out	Jan. 28												
PCES Updates	Mar. 30	June	Sept.	Dec.									
Governance Structure	Feb												
Securing Funding Commitments													
Owner's Rep	Feb. 5												
Owner's Rep Recommendation to ADAMH	Mar. 23												
Owner's Rep Recommendation to FC	Mar. 30												
Operator RFP	March												
Operator Recommendation		June											
Call Center Planning & Implementation (P&I)													
Mobile Response (P&I)													
Crisis Center Groundbreaking													
Crisis Center Go-Live													

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