TOPIC: ENGAGING MULTIPLE FUNDERS IN THE IDEAL CRISIS SYSTEM

A GUIDE FOR LOCAL AND STATE SYSTEMS

OUTLINE: DECEMBER 2021

I. Introduction
   - A. Roadmap Recommendations with Measurable Indicators
     - i. All funders support one crisis system (use quotes from Roadmap)
     - ii. All people are eligible for one crisis system (use quotes from Roadmap)
   - B. Purpose of this Guide
     - i. This guide is designed for use by system leaders at the state and local level
     - ii. This guide is ideally designed for use within an accountable entity and crisis collaboration (Reference the Roadmap.)
     - iii. The goal is to bring funders into the collaboration as partners and help to define their roles and contributions within that partnership.

II. Area of Focus 1: Funders and Their Roles
   - A. Key Component: General approach: Each funder listed has a role in the collaboration
     - I. Supporting Detail: Each funder has something to gain
     - II. Each funder has potential contribution, in cash or in kind
   - B. State Funding – Department of MH/SUD
   - C. County/Local System Funding – BH, CJ, JJ, etc.
   - D. Medicaid
   - E. Medicaid MCOs
   - F.
   - G. Other insurers including Medicare Advantage
   - H. Health Systems
   - I. EMS and First Responders
   - J. Other Community Funders

III. Area of Focus 2: Building the Partnership
   - A. Creating trust
     - I. Don't start with money
     - II. Develop shared vision and values
     - III. Contribute time and resources to the planning FIRST
   - B. Creating a vision for sharing resources
     - I. None of us can build this alone
     - II. The more contributors, the less each one's contribution
     - III. Everyone has something to offer and something to gain
     - IV. As we plan, and demonstrate potential value, it will be easier for each partner to identify its contribution, and measure value for itself and its constituents.
   - C. Goal of improving service and results, not saving money
     - I. An ideal crisis system may cost more than what we do now
     - II. An ideal crisis system represents a similar investment in BH crisis as we currently do for medical crisis
     - III. We don't have to justify that having a well-functioning EMS system saves money; we spend money because it saves lives.

IV. An ideal crisis system may have opportunities for more efficient resource utilization but may or may not "save money" overall.

IV. Making the Business Case

A. What is a "business case"? How does our investment in this produce value for us?

B. State – Invest in building capacity and supportive infrastructure at the local level, rather than funding the whole system. Work to leverage more efficient use of state resources through the collaboration with local systems. Reduce use of unmatched state dollars. Reduce costs in partner systems (DOC).

C. County/Local – Use local funds to improve community response and reduce inappropriate shift into other county or local sources, such as jail, court, homeless shelters.

D. Medicaid + MCOs: Reduce overspending on ER and inpatient services for those for whom no better alternatives are available. Improve continuity of care and recidivism by promoting continuity. As the highest volume funder, invest in capacity that can attract multiple other funders to improve leverage.

E. Insurers: Reduce overspending on ER and inpatient services for those for whom no better alternatives are available. Improve continuity of care and recidivism by promoting continuity.

F. Health Systems: Invest in reducing ER backlogs and boarding.

G. EMS and First Responders: Invest in improving efficiency of utilization of scare first responder time and energy that would be better spent in other areas. Examples include reducing police drop-off times, creating alternative transportation mechanisms to reduce wasteful high-cost ambulance use, etc.

H. Other Funders: Community building investments (including capitalization) by foundations, business community.

V. Making the Parity Case

A. What is the parity case? Continuing reminder that BH crisis response and the continuum of service should be analogous to what is routinely available for people with severe medical conditions.

B. Continuing reminder that it is more efficient when all payers support the same continuum of services (parity across payers).

C. Examples: Supporting equivalent service intensity for medical emergencies and BH emergencies. Supporting non-hospital based intensive services for people with acute needs: medical examples include OP surgery, home nursing, and residential and intensive OP rehab for post-stroke or post-head injury patients.

D. Examples: When our community develops a "cancer center" we don't think about how it will save money; we think about how it will improve care and generate revenue. Shouldn't we think the same about a BH crisis continuum?