Funding and Parity Sub-group **09/23/19**

Timeline Table and Strategy Activity

End States chosen from the listening tour themes:

- Let's get people who don't need emergency services out of the hospital.
- Ensure an equitable distribution of access and resources. If there are no new resources, how can we be smarter?
- Create alternatives to ER for people that don't need that level of care. Are crisis screeners just automatically telling people to meet at the ER? Why not meet elsewhere to avoid pushing people to the ERs?

*Sub-group addition- let's be ensure that ED visits are actually resolved in 4-8 hours!

Working Theory- Assume little to no new funding available. When thinking about funding options, savings for reinvestment are most likely to be created through *avoided* ED visits and hospitalization.

Task- identify funding steps/actions/resources necessary to create alternatives to hospitalization.

Discussion about ED alternatives-

Idea- expand crisis supports at designated agency- available across from the main entrance and into a treatment room at the agencies.

Considerations:

- Building this up as an alternative requires funding and staff and reorganization.
- Staff coverage is a struggle with evenings and weekends- at a DA it can be a safe environment for crisis supports during the day. At 11:30 at night it is not as safe an environment.
- Suicidality or homicidal – if we do need to act toward involuntary- then that is really challenging to do in the community.

Idea- Create a pre-admission room in/next to the ED to meet risk aversion concerns.

Examples to build on from listening tour:

- Alameda model- inpatient psych ER.
- Living room model- connections

Have a pre-admission space?

Idea- attracted to the notion of the urgent care model- express care network that can be created with mental health staffing.

Consideration:

- Staff feeling safe in terms of responding.
- Having a model that builds off of where there are more resources in one area and it being more mobile
    - Rather than recreating everything- can we make it mobile?

Discussion: Alternatives to ED- consider locations and resources allocations. Looked at VDH FTE map of MH positions in the state. *Recommendation* to identify the Designated Hospital Catchment areas as a part of the mapping.

Idea- public education/training campaign

- More education about reaching services during the workweek but we need to determine after hour and weekend times how to keep people safe both clients and staff.
- Sufficient training for folks that are the first line of contact.-
    - Often the screeners are saying lets meet at the hospital
    - Having a knowledgeable individual who knows the resources

Discussion: Ideas about how to fund the resources needed to set up a new plan.

- How do you reallocate the existing resources?
- Funds should go back to the community- but who has the money?
- Hospitals have funds, but… but where is the incentive to move it from the hospital to the community? Hospital earns revenue on hospitalizations, not use of community resources. Need to understand and have accountability for total cost of care. Use the All-Payer Model as a way to establish this?
- Data- share data on the street workers and the success of that to see avoiding hospitalizations. Use this to encourage expansion.
    - A lot of people complained but many communities said they didn't want those resources.
- Need a way to determine outcomes that are expected- if you want a hospital to invest
- All payer model- Onecare is incentivizing not having people be readmitted. GMCB and legislature have a role in this.
- We are asking to reduce volume in an area that has the workforce and increasing volume in an area that doesn't have the resources.

Community-based ED alternative considerations

- What are steps in workflow? Pre-admission- screener sees them, gets concerned wants to EE them.- worst case scenario, what do you do?
- *Idea*- Adopting a protocol to look for warning signs – similar to a heart attack.

Idea- When we think about payment: can we look at an episode of care for crisis across community and hospital supports? Try to create an average cost based on past experience. Create an accountability mechanism so there is something like a shared savings payment model that could start to create a resource sharing opportunity?

Considerations:

- What is the total cost- of a crisis episode? – map that and then looking at that to see what the steps would be…creating an average episode of care and look into a shared savings.
- Need more clarity on how all the funding streams work- how do we move the elephant along to start getting that done…..incentive based payments can help.
- Someone needs to map out the cost and then propose that to DMH and legislature
- How do we make this a system and have each person be willing to make the adjustments necessary along the way?

Short-Term	**Mid-Term**	**Long-Term**	**End State**
Analysis on mental spending and total cost of care across health care Population impact ☒Children ☒Adults ☒Seniors/Elders ☐Other:_ 1. Steps to accomplish this	*Create a shared cost of care/shared accountability payment model* Population impact ☒Children ☒Adults ☒Seniors/Elders ☐Other:_____ 1. Relies on analysis from the short-term initiative. 2. Identify target for shared accountability such as crisis care	*Move funding more up-stream.* Population impact ☐Children ☐Adults ☐Seniors/Elders ☐Other:_____ 1. Use analysis and results of shared accountability payment model to shift funds.	***Ensure an equitable distribution of access and resources. If there are no new resources, how can we be smarter?*** Population impact ☒Children ☒Adults ☒Seniors/Elders ☐Other:_____

Short-Term	Mid-Term	Long-Term	End State
	that can easily cross community and hospital settings.	2. Create space for peers to be embedded in all practices- new facility, living room model etc…. a. Identify and implement Peer supports and pay	
Identify and research living room models Steps: 1. What is the cost? 2. What are the outcomes? 3. Look at this as an approach rather than a place.	*Start to build alternatives to ED off of existing strengths in each region.* Steps: 1. Identify what exists and build upon existing structures. 2. The residential treatment model. a. Proximity to ED/hospital matters 3. Mobile units that can be placed on campuses 4. Build off of an urgent care model.	Fill in gaps where *existing resources are not sufficient to meet the need.* Steps:	***Let's get people who don't need emergency services out of the hospital.*** ***/*** ***Create alternatives to ER for people that don't need that level of care.*** Population impact ☒Children ☒Adults ☒Seniors/Elders
Public education/training campaign Population impact ☒Children ☒Adults ☒Seniors/Elders ☐Other:_____			

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Steps: • Provide education about reaching services during the workweek • Identify after hour and weekend times how to keep people safe both clients and staff. • Provide sufficient training for folks that are the first line of contact.- o Having a knowledgeable individual who knows the resources			