Breakout Group #6

Mental Health Integration Council meeting

November 9, 2021

Facilitator: Ena Backus, Agency of Human Services, Director of Health Care Reform

1. **Devon Green,** Vice President of Government Relations, Vermont Association of Hospitals & Health Systems
2. **Cindy Seivwright,** Alcohol & Drug Abuse Prevention Division Director, VDH
3. **George Karakabakis,** CEO Health Care & Rehabilitation Services, Vermont Care Partners
4. **Emma Harrigan**, Director of Policy Analysis and Development, Vermont Association of Hospitals & Health Systems
5. **Connie Schutz**, DMH CHILD integration grant
6. Anne Donohue
7. Shayla Livingston
8. Thomas Weigel

Capture insights from Dr Levine and Julie Parker's presentations in the table below.

	Enter your takeaways
What are one to three things that you took away from this morning's presentations?	From Blueprint presentation—realignment in AHS. Suggests bigger role/priority for Blueprint in health reform and policy. Blueprint seems like a very good conduit for further integrating Mental Health into primary care. Would like to know more about the plans for integrating further mental health and primary care and how can we help? It used to be that the sense of integration comes from additional staff connected to the practice. The definition of integration now means that you re-work work streams and hierarchies to work as integrated system instead of "plus-one" system. With the Hub and Spoke and how that program has worked, a big benefit is having something to help support and add to primary care rather than demanding and asking primary care to do more. Focusing also on stigma for persons who are

	seeking substance use dependency treatment. Spoke program helped to integrate substance dependency treatment appropriately into practice. We've had success with this model in Vermont and this is a nice thing to build on—especially the stigma piece. This is a culture shift that the Blueprint/Spoke program can help to support. This (Blueprint) is an excellent model for how to integrate all of care. We are still not understanding how we are not duplicating case management work. The participants in the ACO are doing an additional overlay of care management. The Blueprint is also doing care management. There is no real clarity in where we are doing care management. Concept of a single model should mean de-duplicating care management activities. Don't see this happening yet. Blueprint demonstrates that you can improve quality without it costing more but the model isn't necessarily reducing costs. One step further, at the level of integration we are talking about now there is still "health" and then "mental health" that gets integrated to it. Have no optimism that this can be changed right now but we should be on a trajectory that leads to a doctors visit that is just about "health" mental health and physical health truly as the same. Hopeful that we are transitioning to dealing with all health including preventive care. The Blueprint is trying to coordinate with OneCare ACO. When we are talking about payment reform it is important that the different groups are measuring the same things. We can't ask primary care to be doing different screens for different initiatives. We need alignment with the parameters of care/quality assessment. Good that Blueprint is coordinating with Onecare on this.

Scenario - Myra Mansfield –

48, single, with a 9-year-old son named Fred, and aging parents who live ten miles away in a different town.

Myra has been diagnosed with heart disease, and is struggling with an eating disorder. It appears from bloodwork that Myra's medical conditions have either worsened or that she has not been taking her medications. In addition, Myra is feeling a lot of anxiety, and she has been very angry at work and is not sleeping well. Recently the school has

been complaining of Fred's behavior – his grades are dropping, and he is often late coming to class.

Myra's parents are in their 70s. They both have healthcare challenges of their own, but they help with Fred's care as much as possible. Myra's father no longer drives at night.

When Myra visits a healthcare provider for follow-up and a general status check, she complains that she feels like breathing is difficult, and that she never feels rested. She has lost about 20 lbs in the past six months, and is anxious. She appears angry and depressed.

Current State	
Questions	**Don't forget about Fred and his grandparents!** Responses (please put your initials after your comments so we can follow-up if need be)
What examples of successful integrated care currently exist that would help Myra and her family (no matter how small. It may be one protocol you know of in one provider's office)?	Some primary care practices screen for social determinants of health. These screenings could catch some of these issues. Practices also screen for depression which may not address Myra's needs specifically and it is unclear whether the screening would be followed-up with care. Child Grant—children's health linkage identification. Five year grant that will end a year from now with option for one year extension. Grant tries to work with children that are diagnosed with SMI or at risk for SMI (broad). Clinical staff, care coordinators, and wellness coaches are all employed. Clinicians in one site have been hired who are both wellness coaches and clinicians. We have four sites with wellness coaches defined differently by area. If Myra were in one of these areas (pre-covid) we had co-locations of the wellness coaches at hospitals. We spend a lot of time through these sites trying to address social determinants of health, continue family and support and wellness and provide for activities to support mental health and wellness and to do so remotely during covid. Clinicians have activity bags to support clients who they are working with in therapy. Tries to take seriously issues of money and cultural issues.

	Larger family might be impacted by care coordination and care plans. FQHCs would theoretically be able to attend to the needs of the parents as well.
What examples from this morning are relevant?	Blueprint has self-management programs that could be supportive for Myra. Blueprint practices are supported by CHTs that have a wider and broader depth of experience that could support Myra such as a nutritionist. The Blueprint practices are supported by some population based payment that would give practitioners more flexibility to address the needs around care coordination/work with school and parents.
Are there lessons from the early days of COVID-19 about integration that we may want to consider for this project?	Telehealth could be applicable here. Primary care is being asked to do so many things and we want fully integrated scope of services. COVID did show that there are places where telehealth can be better utilized to provide access to services. If there are more specialized needs are there ways to connect practices to services and for a care coordinator to be involved. Telemonitoring could be useful here—smart scales could be used to transmit information back to providers on weight, heart disease and this could trigger a check-in with the patient and a possible in-person visit instead of remote monitoring. There are also programs for persons with depression to check-in remotely to indicate how they are feeling and to prompt a follow-up as necessary. The issue is how to incorporate all these great new tools into practice. How do you balance having a telehealth counselor and ensuring that the telehealth counselor really works as a part of the integrated care team and isn't completely remote and disconnected.

	If someone in a remote location or other state is a really good fit for a person who has specific needs, how does this person get ideally integrated into the team and work in a way that is connected to the practice. The remote person should understand a patient's full care plan. The medical record is problematic for information sharing but there are ways to address this issue and some learnings that can be applied from SUD treatment models. With lack of resources sometimes in primary care, people without resources don't have as much choice to find a good fit and telehealth can help to integrate clinicians that may be outside the care team with the established care team. There are at least three differences pre/post covid: before covid you made a choice about whether you are talking to clinicians in your office or elsewhere. After covid, you are talking with people remotely no matter whether they are in office or outside of office. The check-in for clinicians is easier than it was before. When we talk about being patient-centered and strengths based we've still had a one-size system. After covid, some people are much easier to catch-up with through remote means. Rooms at Springfield are private for parents to do telehealth appointments in a sphere where there is privacy. There are more ways to work outside of the box to accommodate variety of needs for care relationships and privacy. There is a greater spirit of collaboration that has emerged in the face of COVID-19.

FUTURE STATE

Imagine ideal care for Myra and her family. Myra's healthcare team can provide what she and her family need to thrive, **AND** it is delivered in the most effective and efficient manner possible.

Don't forget about Fred and his grandparents!

Questions	**Responses** **(please put your initials after your comments so we can follow up if need be)**

Describe the ideal care - what services does Myra receive?	Peers would be co-located in the primary care office and available to connect on the spot with an individual. Peers are in addition to mental health practitioners who are also co-located and available in office for warm hand-off. Care should be available quickly via a team that understands and has the flexibility to do an assessment or first touch within a few days. We have no urgent care analogy today for mental health and we should have urgent care for mental health. Blueprint and OneCare have a care management model but that model isn't targeting all people/it isn't a model of care for all people. Reimbursement to primary care for doing the coordination that they are doing and are expected to do to integrate all types of care and services that we are discussing. Intensive outpatient care should be an option for Myra. Imbedded social workers are incredibly helpful in practices. If there was a way to have somebody there in the practice for assessment or intake for an urgent/emergent need and connection to services that are outside of the practice. Immediacy is important. Reimbursement should be available to cover the services that are provided in primary care practices that look like the services that Designated Agencies provide. In the ideal, you wouldn't have to go outside of primary care unless needing a highly specialized level of care. Ideally primary mental health care is available in the same location as primary care. There needs to be a data component to inform the ideal and to inform a care team that is working in an integrated fashion. Additional screens can be available and can be coded for reimbursement. There is other data about who is leaving jail, who is entering jail and how do these circumstances impact health and wellbeing of a family. Proactive outreach based on data/survey instruments. A future state includes integrated data streams that together tell a clear picture and indicate areas for meaningful follow-up. And at a site of care, peers are available to help persons

	through the process. Ideally, we are paying for value and outcomes and supporting interconnectedness.
Where does Myra go to get this ideal care? *Is there one location or more than one?* *How far does she have to travel?*	Integration doesn't automatically mean co-location but this goes back to what level of integration you are talking about. There is a fair amount of data to demonstrate primary touches in a co-located space have a lot of impact. In our highly technological world we can see a system of providers consulting and supporting one another in the same system of care. There are some designated agencies with staff co-located in primary care offices. Fundamentally as a system if we are trying to create a system that is truly integrated we wouldn't have a standalone designated agency system. We would want to promote a system of whole health care. The system as built today creates an obstacle to integration. Designated Agencies turn to specialty centers (example eating disorder specialty) primary mental health care functions of designated agencies would be truly integrated with primary care practices. In ideal world, Myra would assess what is most important to her and prioritize from a range of options what would be most helpful to her at that point in time. Integration should be more collaborative, less hierarchical and includes the patient as the primary driver of change. There is not ideal care that fits everybody. We have to bridge this space. One important change goes back to medical/health care provider training. Providers need training to listen to patient input.
What kinds of care/services are provided for Fred and his grandparents?	

How is the care paid for?	
What kind of training did her healthcare providers receive?	
How will everyone know if Myra and her family's needs are met?	This is linked to involving the patient and finding out if the patient's needs are being met. My care survey where people are asked where they are in their lives and what has changed for them. This is an important piece. Common sense is also really important. If you increase screening you will get more "positive" screens. Needs/utilization go up when proactively addressing peoples' needs. You need to tell the story that goes with the data.
What are the top three performance measures the team aims to excel at?	

Preparing for report-out

What are your top three insights that you are taking away from this exercise?

1. A certain level of mental health need should be addressed directly in primary care by a present team member and peers
2. Patient-centeredness is crucial and there is not a clear working definition.
3. The system needs to become a learning organization that doesn't assume that it has all the answers. Collaboration is strong but people do not feel responsible for the outcomes of a team as a whole and this needs to be changed through leadership and training/education.
4. Reimbursement and multiple overlapping models of care coordination/management were also key themes.