Mental Health Integration Council
March 8, 2022

Funding & Alignment of Performance Measures Workgroup Notes

11:00 Break into our four Workgroups to discuss learnings from the discussion between Dr. Levine, Alison and Dr. Gaudet and to come up with your definition/description of integration.

Ask for volunteer to take notes (share link to Google doc and share your screen)

Either now or at the end, Choose someone to report out to the Council.

This is an opportunity to pause and reflect on what we've heard and begin to identify what we wish to see for integrated care.

1) As you consider the three models we've discussed (CCBHCs, FQHCs and the Whole Health Model) and other models you're familiar with, jot down the aspects of these models you believe would best support effective integration in Vermont.

2) Go around the group and ask them to share what they took away (volunteer scribe captures notes on this document, below). Make sure that everyone is invited to speak.

3) If you were asked to describe integration five years from now and Vermont has achieved an integrated process that Vermonters appreciate and value, from the role you represent, how would you describe what that looks like?

NOTES:

1) **Personal reflection: As you consider the three models we've discussed (CCBHCs, FQHCs and the Whole Health Model) and other models you're familiar with, jot down the aspects of these models you believe would best support effective integration in Vermont.**
   - Concept for FQHC having all services under one roof. Experienced this previously and it was beneficial. Would love to think more about leveraging resources across a stressed system.
   - Transportation is an issue and the state is rural. It would be beneficial to have everything under a single roof.
   - Appreciated the comment about getting community input on what the system should look like. This is easier said than done.
   - How do we leverage and integrate the current systems we have in place instead of creating all new ones. Grassroots aspect allows communities to be the driver of the integration work.
   - Resource mapping is interesting and how can we go about this in a non-siloed manner. Also interested in value and parity in how we pay for high value. How do you truly bring in all of the siloes to make change? Need to define integration to decide what is included.

- There is still a question about who is in charge or accountable if it is community-driven. How does this impact the selection of performance measurement. Measurement demonstrates our values.
- Re: accountability, we have an ACO that is accountable for some things but not all things. View the healthcare system as an ecosystem that can be influenced but no one is in control of it. In many other countries, these items are called social services and not health care. We continually try to squeeze more into Medicaid and now we are so reliant on the federal match which limits our flexibility. Few clinicians are unable to spend the time to understand the data. Can understand what is valued by looking at the budget of an organization/system.
- Note that we are now in a Medicaid corner given the evolution of Global Commitment over the last 20 years. We still need to make progress even if Medicaid is not the end all. What we are looking at is the CCBHC. Need to move to having one overarching set of principles and this is one mechanism to get to this place as it has buy-in at the state and local level. Advantages to fill in some of the gaps and have flexibilities. There are other pieces to this beyond health care such as corrections, housing, etc. There is a lot of redundancy in the system that can be removed and we should build from what we have.
- Agree with comments. Everyone is having these conversations separately and sometimes they are redundant or conflicting. We should start with the basic purpose statement of why we want to integrate care. If we need to answer the question about what the best model is, then we should be asking people who receive services. Maybe 80% of people in VT would want everything to be located in one place but whatever we do can't be a rigid one size fits all approach. How do you make the shift by paying for the high value things that are preventative and proactive instead of inpatient and acute needs. If we did this, we would be doing more community-based and peer-based services.
- Decades ago, the department did a profile of the system of care. Showed that if you don't have respite and clinical care at the front end, then you will have a lot of acute needs. Even though this is a 30 year old conversation, having a balanced system of care is still essential.

If you were asked to describe integration five years from now and Vermont has achieved an integrated process that Vermonters appreciate and value, from the role you represent, how would you describe what that looks like?

- Vermonters EASILY/EFFORTLESSLY receive timely, sufficient, affordable care and services that are flexible and dynamic and advances their ability to actively participate in an improved quality of life for them.
- The person does not need to navigate all needs themselves.
- Not one size fits all and is flexible.
- Individuals are treated with respect and we are learning from each other using trauma-informed models and spirituality.

Need to look at data to see what has really worked. This is a good opportunity to make things work – telehealth is a good example and has been praised by many clients who spent considerable amounts of time traveling and prefer to be engaging from home.

- "Don't let a good pandemic go to waste" – we should be embracing alternative methods.

11:45 – Workgroups report out to Council