Mental Health Integration Council

Achieving an Integrated Health Care system that serves every Vermonter

Meeting November 9, 2021

Themes from Breakout Groups

Responses to Blueprint for Health presentation

1) Importance of multi-faceted approach
    a. Rapid access to right care level – can this be applied to MH Care?
    b. Crisis vs. step-down – how do these work together?
2) Workforce challenges
    a. Training
        i. cross-training
        ii. communication – language/jargon differences, can lead to misunderstandings
        iii. How to collaborate effectively
    b. Simply need MORE staff
        i. Is the BP helping or hurting the system? The case study really showed that they rely on the DA system however they take staff from the DA system.
        ii. Expand the MH workforce with peer support workers for human resources that are not only evidence-based but also cost effective.
        iii. Consider lessons from peer recovery support coach and apply to mental health peer supports.
3) Do Community Health Teams collaborate with corrections?
    a. Discussed the importance of restorative justice and how that has diverted many individuals away from the criminal justice system.
    b. Currently, the individuals who are involved with Dept. of Corrections have acute needs, trauma, criminogenic factors, mental health challenges.
    c. Corrections uses the hub and spoke system. Have connected to the Blueprint for care for individuals.
4) Basic respite care no longer exists. When you try to keep people in the community and need high level of services then it eats all the services for everyone else. We need both.
    a. Where has the respite money gone?
    b. Need more acute beds, but maybe not just more beds
    c. Need to provide more funding and top-down support for community services including peer support e.g. peer respite beds in addition to inpatient psych beds
5) Evidence based and accountability –
    a. Does the BP yield the outcomes that they started with?
    b. Are people receiving services faster with BP?

    c. We need alignment across care/quality assessment. Good that Blueprint is coordinating with OneCare on this.
6) The vision of the BP needs to be updated.
    a. Need to provide these services while individuals are waiting in the ED.
    b. Need realignment in AHS. Suggests bigger role/priority for Blueprint in health reform and policy.
    c. Not everyone comfortable getting care in medical setting. How expand Blueprint to serve these people?
    d. Good conduit for integrating mental health into primary care.
        i. Blueprint demonstrates that you can improve quality without it costing more but the model isn't necessarily reducing costs.
        ii. 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.
    e. Integration still about "health" and "mental health."
        i. We should be on a trajectory that leads to a doctor's visit that is just about "health" - including preventive care.
    f. Hub & Spoke shows benefit of adding to primary care rather than simply asking primary care to do more.
    g. Stigma – Hub & Spoke helped address reduce stigma around substance use.
7) Language
    a. Avoid terms that offend or marginalize certain communities, e.g. "behavioral health"
    b. The use of the term, "peers" still holds a degree of concern.
    c. Let's talk about the "others" that were not defined.
8) Green Mountain Care Board
    a. Needs to integrate mental health into regulatory work

Scenario

We heard/read the following scenario and responded to a series of questions.

> Myra Mansfield is 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 Discussion

Examples of successful integrated care that would help Myra and her family

1) "One stop shopping" –
    a. Integrated care
        i. FQHC could provide integrated care and ensure mental health is also addressed.
        ii. Care coordination that shifts lens from individual to family & community
            1. Ensure care team and family aware of all relevant supports and how to access them
            2. Community Health Team
            3. Council on Aging, Eldercare Outreach Clinician, Home Health, SASH
            4. Community Health Workers
        iii. Releases in place (if appropriate) so she can talk to providers about her parents.
        iv. Identify what Myra does for work and what her relationship is with her parents to indicate the resources that she needs to be connected to.
        v. Use patient messaging to allow Myra to contact providers directly.
        vi. Pediatric care
            1. CHILD grant Wellness Coaches
    b. Need to address primary care needs first so she can take care of her son.
        i. Explore why not taking meds – what is contributing to this, are there routines or other supports needed?

    c. Use the AIMs model – Ambulatory Integration of the Medical and Social Model of Social Work Consultation and Care Coordination - within the clinic that is embedded with primary care.
    d. Get more information about what is going on in her life. Is there an intimate partner?
    e. Does Myra need transportation support (Medicaid)?
    f. Additional support
        i. On-line groups
            1. Dialectical Behavioral Therapy
            2. Eating support
            3. Online therapy
        ii. Peer support
2) Screenings (and review outcomes with members of integrated care team)
    a. Substance use
    b. Social determinants of health
    c. Depression & anxiety
        i. Is breathing rate high, or are there psychiatric/psychological contributors?
        ii. MH-PHQ9 for depression
        iii. GAD7 Anxiety
    d. ACEs
    e. Suicidality
        i. Dept of Mental Health "mini grant" project in partnership with the Center for Health and Learning and the Blueprint to develop a coordinated work flow for assessing and referring for suicidality. PCPs partnered with local DAs to developed protocols for assessing depression and suicidality, and a "what to do" document if a need is identified.
3) School supports
    a. Coordinate with school nurse and counselor
        i. Help with morning routine and challenges making Fred late for school.
4) Pediatric supports
    a. Assess for food insecurity
    b. Parent-Child centers

What examples from the Blueprint presentation are relevant?

1) A community health team could help
2) Does Myra's financial status matter in how she receives care, and if so, why?
3) Telehealth is an excellent tool
4) Wrap-around and care coordination could keep Myra out of the emergency department

Lessons from the Pandemic that may help

1) Telehealth use
    a. Could be in PCP office and connect with psychiatrist or therapist with ease.
    b. Real time connecting with other provider during visit would make care more efficient and integrated
2) Greater focus, education on mental health now---takes some stigma away hopefully.

3) Paying more attention to food insecurity, housing stability and how this impacts physical and mental health.
4) Getting medications delivered
5) Collaboration happened!
    a. Brought in concept of community sense of care/service provision
    b. Focused on coming together for the good of the community. Barriers were minimal.
6) Peer support
    a. Training and financial support for non-professional caregivers of older Vermonters to leverage community resources and support family who want to help aging relatives
7) At UVMMC, so many things were shut down, we identified patients that were high risk to check in on them. The question is, why don't we always do this? Identify through screenings, who needs to be connected to services and to have people notice what is needed.
8) Public Health
    a. fully embrace public health model and funding for promotion and prevention, not just treatment for those experiencing mental health challenges.

Future State

Describe the ideal care - what services does Myra receive?

1) Providing services where and when the family needs it-home, community, etc.
    a. Hours allow patient/client to get care without missing work
    b. Childcare is available and affordable
    c. Home Health Care available and affordable
2) Integration of physical and mental health care
    a. A mental health provider she and Fred have had a long-term relationship with, either at the PCP or a DA.
    b. Not just person-centered care, but family-centered care and more holistic care.
        i. What is most important to Myra?
        ii. What is her culture?
    c. Whole team with primary care, psychiatrist, social worker, and peer with clear protocols
    d. Peer support
    e. Case manager
    f. Support via text
    g. Coordinate with providers
    h. Primary care visit with lab work done immediately, engages practitioner right away around eating disorder.
        i. Nutrition support
    i. Bi-directional care-embedded MH in primary care and primary care in MH
    j. Assessments/screenings done and shared
    k. Trauma informed (parents may be one of Myra's challenges)
3) School supports
    a. such as vaccines, counseling, etc.
4) Timely care
    a. not needing to wait for treatment and care

    b. Urgent is clearly defined and we can respond accordingly as a system.
    c. Primary care visit with lab work done immediately, engages practitioner right away around eating disorder.
5) Equity
    a. quality of care
    b. All have health insurance
    c. All have leave time at work that is paid
    d. Wellness focus for everyone with accessible options, lifestyle activities
    e. Address lack of trust in Native American populations
6) Financial
    a. Simplified billing and payments
    b. There is workforce and staff to provide supports, medical care, mental health care, etc.
    c. Time for care coordination and reimbursement for this.
7) Trauma-informed knowledge and care provided.

Where does Myra go to get this ideal care?

1) As few locations as possible and where it is most convenient for Myra.
2) Choice – Myra should be able to choose where/how she receives care.
    a. Telehealth works for some, not all, but is critical if someone does not have reliable transportation.

How is the care paid for?

1) Health insurance
2) NOT fee for service

What kind of training did her healthcare providers receive?

1) Trauma responsive training
2) Cultural sensitivity

How will everyone know if Myra and her family's needs are met?

1) When Myra says "I really like my life now."

What are the top three performance measures the team aims to excel at?

What are your top three insights?

1) Acknowledgement of the need for a multi-faceted approach
2) Appreciation around the workforce challenges and what is going on
3) Within mental health and physical health care-different culture, language, training, how do we come to commonality and consistency.

1) Need family-centered care where Myra and her family want to receive it.
2) Isolation is the root of most ailments.

3) Timely services, transportation when needed without restriction, flexibility in hours, location.
4) Social supports important for Myra and Grandparents AND for professionals.

1) Does Myra's financial status matter in how she & her family receive care? If so, why? Should it? Lessons from COVID: Stark equity/inequity that people experience - economic (income, housing), racial inequities, access to healthcare. Need to consider this integration effort in terms of equity.
2) Teamed approach and the power of peers.
3) Need Mission Control! There may be a lot of supports/services, but does everyone know about them and how to access and how coordinated. Need family members and practitioners to be aware of everything available and tie it all together.

1) Patient voice/choice
2) Culturally /Trauma informed
3) Integrated Assessment of physical and mental health needs (especially in a family)
4) Integrated tools including face to face/telehealth/outreach

1) The need for care management through the continuum of care and across disciplines
2) The importance of follow up after crisis care
3) The recognition that we do not know enough about what other work organizations and people are doing and it's incredibly helpful to have these conversations to see overlaps, and gaps