Pediatric Subgroup discussion of morning

- Concern about pathologizing and self-fulfilling prophecy. Youth, reasons why may have those symptoms and experiences, to then be labeled with diagnosis and impacts of a diagnosis. Help-seeking behavior leads to diagnosis, are you living your diagnosis? Not good thing.
    - Kids, diagnosis and billing – current ECFMH issue - is it ethical or discriminatory, changes how healthcare system sees you when walk int the door.
    - Some families feel relief in having a diagnosis; sometimes diagnosis won't change the treatment plan. Current diagnoses don't address complex trauma – preventative, early relational attachment. Some teens are owning their diagnoses – opens dialogue around MH, less stigma.
- Prevention and public health approach is less pathology driven, rather than more intervention later to address the established problem.
- What wellness activities and earlier interventions have been tested withing Blueprint and ACO OneCare VT that we can scale up. Wellness access can be inequitable. School environments are place where many kids are
    - Providers can't lift their heads up to have time for wellness. Other entities to do this in partnership?
        - Have someone on team who has wellness as part of role, supported through funding model.
        - Need to look 10-20 years down the road when thinking about our investments now.
        - Effects of CHTs – John trying to collect stories of their effect.
    - CHILD grant wellness coaches, for some families this helped address their concerns and didn't need further MH intervention.
    - Patient navigators combined with wellness could be first point of contact.
    - Schools – may use paraeducators to provide intervention after consultation with specialist. SW intern, peers could be that role. Consider who is first point of contact.
- How do we actually implement the public health approach, rather than continue to treat when issue is identified. Interventions that focus more on protective factors, prevention. Touchpoints.
    - Use the expertise at VDH/SOV and community activists together to address needs in communities together.
        - Grants program through SOV for wellness/prevention activities – list what is known to work – and help community address that public health need. Measurements.
    - Hegg, Logan: Kroll DS, Latham C, Mahal J, Siciliano M, Shea LS, Irwin L, Southworth B, Gitlin DF. A Successful Walk-In Psychiatric Model for Integrated Care. J Am Board Fam Med. 2019 Jul-Aug;32(4):481-489. doi: 10.3122/jabfm.2019.04.180357. PMID: 31300568.
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- John: Do workgroups have experience with CHTs and aspects of Blueprint and what would like to see more of?
    - There may be people who don't realize people are funded through Blueprint funds.
    - Do CHTs do a community needs assessment? There are parts of system that require that to happen. Trying to assess where is that happening well, where weak.
    - Heard Blueprint about to launch a MH initiative? Legislature and Gov passed Act 167 asking Blueprint and Ena whether PMPM should be increased to CHTs given stakeholder input about the need for SUD to extend beyond opioid use and MH needs in PCP.

Developing proposal due to legislature focused on MH/SUD needs. What Gov & Legislature says, unsure yet. Not a MH proposal.

- Dillon invited Blueprint to have productive conversation about this with DA system, referral relationships, DA staff embedded, fears/concerns about workforce.
- Gaps in expertise on CHTs or other providers. Looks different in different parts of state.