MH INTEGRATION COUNCIL
PEDIATRIC SUBGROUP

DATE: DECEMBER 21, 2021

TIME: 10:00 – 11:30 AM

LOCATION: Virtual meeting (audio and visuals): Microsoft Teams

Click here to join the meeting

Or call in (audio only) +1 802-552-8456,,727176506# United States, Montpelier

Phone Conference ID: 727 176 506#

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WELCOME & INTRODUCTIONS — LAUREL

Workgroup Members:

☒ Ward Nial, Representative, National Alliance on Mental Health

☒ Heather Bouchey, Deputy Secretary, Agency of Education

☒ Mike Fisher, Office of the Health Care Advocate

☒ Dillon Burns, Mental Health Services Director, VT Care Partners

☒ Sandi Yandow, Representative Vermont Federation of Families for Children's Mental Health

☐ Dr. Harris Strokoff, Representative, Blue Cross Blue Shield

☒ Emma Harrigan, Director of Policy Analysis and Development, Vermont Association of Hospitals & Health Systems

☐ Ilisa Stalberg, VDH Maternal Child Health

☒ Dr. Breena Holmes, UVM, VT Child Health Improvement Program

☐ Dr. Sara Pawlowski, UVMMC psychiatrist, pediatric integration

☒ Dr. Logan Hegg, UVMMC psychologist, pediatric integration

☒ Connie Schutz, DMH CHILD integration grant

☐ Julie Parker, DVHA Blueprint

☒ Laurel Omland, DMH Child, Adolescent & Family Unit

Member of the public:

Dr. Stephanie Winters (VT Medical Society, AAP-Peds, APA-VT, Assoc Family Practitioners)

AGENDA

SMART GOALS	LAUREL

Description:

Inform ☒

Discuss ☒

Decide ☐

- Moving forward with Global Learning Partners to help facilitate these meetings
- **Smart Goals**

Any progress on identifying measures for integration, existing data sources exist that you have access to from your position?

Emma offered to help translate some of the discussion into Indicators & Performance Measures

–> Laurel sched meeting.

What is some small action(s) that you would either like to see or can put into action in the next 6-months to move integration forward?

Discussion:

- How to stay in the loop about legislation underway that impacts this, but not have it take over the agenda/discussions.
- What we need:
  - Want more humans to meet SEL/MH needs of kids who enter healthcare system, schools need some general principles in place for how to respond rapidly without new model (define school's role, where are resources). Need more care coordination. Kids are in homes, schools, medical homes.
  - Consider: Blueprint needs more funding to the CHTs to allow all to have a MH/SW on every team, not to the exclusion of another key role.
    - Yet, these roles often are filled by people from DAs to become yet another referral entity to a provider network (MH/DAs) that is further diminished. **Cannot be zero sum game**.
    - Blueprint wasn't designed around children. Community autonomy means might not have someone on team who knows pediatrics/MH. There's an understanding a local level of what are their needs. **Could consider minimum standard for them to think about. E.g. Blueprint team has a pediatric focus that supports CYF mental health needs.** (rework wording)
  - Organize system that meets family's needs.
    - Do families understand where to go when are in crisis?
    - Does this group understand why our system is currently in level of crisis?
  - More people in service of attachment, starting with new baby, as protective factor of future. Brief discussion of Touchpoints initiative, work in early childhood
  - Kids waiting in ED – is indicator/metric for us to keep eye on as to how other actions are impacting that data point. Look at syndromic surveillance data (Caitlyn Quinn), might have lens to consider.
  - How to keep broad integration lens – who's on your team? Idea: Ask at ED of every youth, do you have a Coordinated Services Plan. Who would take that on?

Crisis of wait time shows up at the ED. In some ways, that's too late. Ask if have crisis plan. CSP is coordinating across entities.

- We have the systems, need enhancements to truly benefit from them and link with other parts
- There are basic skills that are beneficial for everyone to understand to build resiliency. For Vermonters.

- **What financial questions would you want to put out to the fiscal workgroup?**

Can share bullets from discussion. Are there pointed recommendations or questions to pass on?

- Medical debt is issue that Mike Fisher has talked about more broadly. Stress & access to healthcare. Parents often said: my kid's getting care and I'm not (b/c financially cannot take that on, but long-term ramifications)
- Structural problems that seem finance related – can raise it to the other workgroup.
- Schools are also underwater. Feels like the school financing challenges puts pressure on not recognizing MH issues for kids. Comment: Schools often know what are needs among students, but not rising to level of getting services b/c of school finances.
    - AOE has put focus on SEL/MH, is this about long-standing challenges?
    - Patterns of schools not recognizing kids with special ed needs. Believe has to do with finances.
    - What's getting integrated for kids? Schools increasingly being asked to take on more than academics. How address this in integrated way and statewide?
        - Balance of local control, state guidance/minimum standards
    - A lot of work is happening related to better understanding how school MH finances work – separate workgroup of AOE, DMH, districts, provider agencies (DAs).
    - Act 173 in process, reform of Special Ed funding and services. Goal is to allow supports to be available earlier for students, before has impact on academics (current Special Ed requirement).
    - Universal training for teachers & students to understand MH needs is also underway (MH First Aid, CHL Suicide Prevention trainings).
- **Recommend**: Executive summary from each MH Integration Council Sub-group to pass on to the other workgroups. Bullets to pass on.
- Providers might struggle to lift up eyes above the current work to look at systems. Describe communities where partnerships exist, providers know each other and coordinate/ collaborate. E.g. School nurses feel disconnected from work of MH system. What are communication tools, how to model for communities how coordination can happen.
- **Public comment**: physicians saying to legislators not to identify new flashy things (although need to address people boarding in EDs), want more integration into PCPs. For example, Blueprint is great, but need more of that help, more funding to support Social Workers/ clinicians in PCP office. CPAP link for PCPs to access psychiatric consultation. Use current workforce to provide more collaborative care models. Look at what's already happening that is currently supporting long-term goals, and resource that better.

- Clear vision (for system) will help fight mission creep (for providers/sectors within system). Clarity of roles.
  - **Workforce development**: help different providers to know how to collaborate within their role and know where connect to the broader whole so don't feel are taking it all on and in isolation.

MH INTEGRATION COUNCIL MEETING 1/11/2022

Will be discussing several integration models: CCBHCs, FQHCs. Guest speakers (to be confirmed) are:

- Brett Beckerson, Director, Public Policy & Advocacy, National Council for Mental Well-Being
- Jane King, Senior Consultant, National Council for Mental Well-Being
- Christie Everett, Clara Martin Center, Randolph, VT – Designated Agency implementing the CCBHC model
- Michael Costa, Northern Counties Health Care, St. Johnsbury, VT – Federally Qualified Healthcare Centers

What questions would you like to pose to the panel in Jan?

Inform ☐
Discuss ☒
Decide ☐

CLOSING & NEXT STEPS

Key Points from today: see blue font.

Inform ☐
Discuss ☐
Decide ☐

NEXT MEETING: Jan 18th for subgroup. MH Integration Council meets 1/11/2022.