CCBHC Community Public Meeting

Tuesday, November 12, 2024
11:30-1:00

Location: Microsoft Teams or Weeks Building, Waterbury
Facilitator: Lori Vadakin, DMH, Director Mental Health and Health Care Integration

Purpose: The monthly meeting aims to establish a clear message on the progress of Certified Community-Based Integrated Health Centers (CCBHCs) in Vermont. The Department of Mental Health's mission is to enhance the health of Vermonters, and pursuing CCBHC status aligns with this goal by integrating mental health, substance use disorder treatment, health equity, and physical health into a comprehensive care approach. This model supports the State's broader efforts to integrate services across the health care sector, as outlined by the Mental Health Integration Council.

For information on CCBHC and notes please go to:
Certified Community-Based Integrated Health Centers (CCBHCs) | Department of Mental Health (vermont.gov)

Attendees:
Amy Guidice, Laura Flint, Lori Vadakin, Eva Dayon, Cheryle Wilcox, Laurel Omland, Puja Senning, Patty Breneman, Sam Sweet, Steve DeVoe, Amy Guidice, Laura Corbet, Emily Roemer, Emily VanDeWeert, Cheryle Huntley, Kathy Monty, Jo Berry, Tori Matteson, Carri, Ashley Wheeler, Kheya Ganguly, Christie Everett, Cynthia Taylor-Patch, Mitchell Barron, Jenni Campbell, Lee Ann David, Megan Mitchell, Michael Dooley, Trisha Ketchum, Cynthia Harrington, Ken Gingras, Ashley Wohlford, Chani Jain, Haley McGowan, Cara Capparelli, Alison Neto, Karen Carreira, Trevor Hanbridge, Renee Weeks, Rob Mitchel, Victoria Potter, Eric Ruiz, Elora Taylor, Bill Claessens, Julie Pagliccia, Danielle Mitchell, Simone Rueschemeyer, Amelia Duffy, Denis Houle, Daisy Berbeco, Alya Reeve, Julie Parker, Chuck Myers, Micheal Dooley, Jessica Kell

Land Acknowledgement presented by Laura Flint:

As we gather for the CCBHC Public meeting, we recognize that we live and work in Wôbanakik, Dawnland, the historical and current homeland of the Abenaki people. We acknowledge the long history of genocide and land theft that was used to create what we now know as the State of Vermont, as part of the United States of America. We honor and respect the enduring relationship between Indigenous people and their territories, as well as the many contributions of the Abenaki that have shaped the history and culture of this region.

As we approach the Thanksgiving holiday, we reflect on the complex history this season represents, particularly for Indigenous communities. We recognize that Thanksgiving has historically overlooked the injustices faced by Native peoples and has sometimes perpetuated harmful narratives. This year, we commit to deepening our understanding of that history and honoring Indigenous perspectives.

The work that brings us together today must also ensure that the voices of the Abenaki people are included and respected. Thank you for joining us in this acknowledgment and in building a more inclusive and respectful community for all.

Agenda Item	Discussion Notes
Welcome ~ Lori Vadakin	• Today is the fourth of a series of monthly public meetings DMH will be holding to ensure we are keeping community members up to date with our CCBHC efforts in Vermont. All agendas and minutes for these public meetings can be found on the DMH Web site at Certified Community-Based Integrated Health Centers (CCBHCs) | Department of Mental Health (vermont.gov)
Opening Remarks ~ Cheryle Wilcox	• Today's agenda is focused on how CCBHCs serve the needs of children and families. There have been many efforts to support a more integrated system of care for children and families including Children's Integrated Services, Act 264, Integrating Family Services, and the upcoming effort to support Team Based Care for children and adults by AHS. • See below for full transcript

CCBHC Child, Adolescent, and Family Services ~ Laurel Omland	• See slides
	• Overview of VT System of Care, EPSDT Requirements, Act 264, Local Interagency Teams, Coordinated Services Plan (CSP), Children's Mental Health System of Care, Mental Health System of Care (need to discuss what is included in CCBHC and what is not), Home and Community Based Services (HCBS), CCBHC required services and CYFS considerations, SAMHSA Comprehensive Crisis Continuum of Care, Potential opportunities under CCBHC as related to CYFS, Exclusions from CCBHC for CYFS, outstanding questions for CYFS
	• Discussion on how this all fits in with CCBHCs – how the system currently functions and what the pivot to CCBHC will mean.
	
	CMC/Rutland
	• **CMC**: Jenni Campbell/Micheal Dooley: Four aspects that they have been able to be creative with under CCBHC:
	  • **Transition Age Youth (TAY):** Assessed barriers to accessing the TAY programming, re-instated and expanded adventure program, building groups, building community collaborations.
	  • **Same Day Assessment:** Large waitlist led to shift in clinic based scheduling and same day assessment – all age groups, 4 days per week. Waitlist gone. Starting this week they are running afternoon/early evening trial.
	  • **Nursing Care:** Through CCBHC, expanded nursing offerings. Hired a nurse to assist in consultation with psychiatry, integration of MH and SUD, Holistic wellness and care, family check-ins, medical oversight, nursing education in groups, and care coordination with local medical organizations.
	  • **Peer Support Work:** Youth engaged in other services can

	access youth peer-based support. Looking to provide family peer support as well.
	• **Rutland:** Cynthia Taylor-Patch: Third year of CCBHC grant. Similar to CMC: added nursing care/medical consultation, expanding care coordination, training initiatives (family therapy, group facilitation), peer support work (focus on working with youth and families). Focus on four primary areas:
	  • **Service Access:** Process improvement to expand capacity, piloted initiative for same day access and looking to move into CYFS.
	  • **Adolescent SUD:** Develop programming and workflows, consultation to develop youth centered SUD programming. Developing an engaging space for youth.
	  • **LGBTQ+ Youth:** Quality improvement team looking at data to determine what can be implemented, outreach events, including all youth in the community and not only clients.
	  • **Access to Psychiatry for Young People:** Looking at data and community needs – process improvement to identify barriers and how to impact.
	
	Questions/Comments:
	• Great work!
	• Did Same Day Assessment create bottleneck with ongoing appointments? Per Jenni, SDA did not create a bottleneck. They staggered the process with smaller groups to control the work, tightened discharge process. Per Michael, geography and staffing levels required planning to disseminate information on the development of the processes – building process documentation to help. While program development may be quicker, building engagement is the longer phase.
	• How long have you found that it takes to implement fully your new youth programs; at Rutland it seems many are currently in planning? Per Cynthia, depends on complexity of service - some of the programming has been implemented, some programming is in planning and they need to wait for funding to support.
	• Cheryle – Vermont seems to be ahead of many states in engagement of youth and families
	• Laurel: are there areas with questions/pinch points?
	  • Important to build TAY into funding – engagement prior to intake
	  • What does it mean that Success Beyond Six is excluded? How to provide outpatient services at schools?
	  • CCBHC is meant to increase access to care but with private insurance does not pay for non-therapy services (case management services, individual community supports, group community supports, etc)
	  • Flexibility and funding for transportation, especially in rural areas where public transportation is not available.

Quality Measures & Data Collection and Reporting ~ Steve	• Kickoff meeting in Oct – reviewed 18 quality measures (5 clinic and 13 state collected). Reviewed data reporting template. Stratification by age, payor, demographics.

DeVoe	• Next meeting is on December 2 from 2-3pm on Teams.
Community Needs Assessment ~ Laura Flint	• Shared draft CNA Guide with Adult and CYFS standing committees. Shared link to National Council toolkit and PowerPoint with overview. Feedback includes mention of comprehensive template. Centers can do their CNA in a way that works for them but need to report in the template so various areas can be compared/aggregated. Suggestions to reach out to additional groups: Youth Council members, soup kitchens, community centers for older Vermonters, family centers, regional offices, primary care providers, advocacy organizations, patient advocates, etc. Suggest to get into the community to get feedback (as opposed to surveys). Also, using local community needs assessments for information to not duplicate work. • Postpone work on CNA draft to prioritize Certification Guide.

Communications (internal and external) ~ Laura Flint and Lori Vadakin	• Report out on topics requested:
	  • CYFS: Today's meeting
	  • Hub and Spoke: One pager on DMH website (link)
	  • Finance and Billing: most questions have been answered in meetings.

Finance/Billing ~ Shannon Thompson	• No report
Certification, Recertification & Clinical Services ~Eva Dayon	• No report. All materials on the DMH website are up to date
Public Comment, Q&A	• When will the final code list be shared? The draft billing/coding list will be posted to the DMH website this week, though clarifications may be added until April.

Opening Remarks:
Introduction—Cheryle Wilcox—social worker who has been in the field for 26 years now. Next month, I will be in my current role for 10 years. My role has shifted over the years but one thing has remained the same – the focus on how at AHS we can pull together in the same direction to make accessing supports and services easier for Vermonters.

Today's agenda is focused on how CCBHCs serve the needs of children and families. There have been many efforts to support a more integrated system of care for children and families including Children's Integrated Services, Act 264, Integrating Family Services, and the upcoming effort to support Team Based Care for children and adults by AHS.

In 1988, Act 264 was passed which entitles families to coordination of services across AHS and AOE—this started just for children with a Severe Emotional Disturbance (federal term) and was expanded to cover 16 different disability categories in 2005 with an interagency agreement across AHS and AOE—including DD, MH, SU, learning impairment, visual or hearing impairment; speech or language impairment; orthopedic impairment (result of congenital anomaly, disease or other condition); autism; traumatic brain injury.

As well, this is an important time to recognize IFS-Integrating Family Services which started in 2012 with CSAC and ACPCC and then in 2014 with NCSS. It is important to remember these

pilots because they leaned in to try something that hadn't been done before with payments and this led to innovations in the children's system of care. This initiative consolidated over 30 state and federal funding streams from VDH, DMH, DAIL, DCF, and DSU into one unified case rate with the intent of integrating services for children and their families around providing services, supports and treatment earlier to ***prevent more intense needs, to achieve better outcomes and spend funding more efficiently***. This meant not needing to focus on a silo—what was the main presenting challenge to be addressed-and instead shifted to what does this child and family need??

The lessons learned from IFS informed payment reform which started in Jan. 2019 to move all Designated Mental Health Agencies moving out of FFS and into case rates for both children and adults.

The common theme through all of these efforts which we are now holding with CCBHCs was more ability to offer person-centered care, get out of siloed funding, and provide the right services at the right time.

The time, energy, and commitment from community agencies and state partners who are working together across all realms—fiscal, supports, clinical, certification—to evolve our system of care shows the innovation, dedication, and compassion that exists. This is what makes large system change possible and successful.