Interim Report to
The Vermont Legislature

Mental Health Integration Council

In Accordance with Act 140, Section 4

Submitted to:	House Committee on Health Care Senate Committee on Health and Welfare
Submitted by:	Alison Krompf, Deputy Commissioner, Department of Mental Health Mark Levine, MD, Commissioner, Department of Health
Prepared by:	Kathleen Hentcy, Mental Health & Health Care Integration Director, Department of Mental Health
Report Date:	January 15, 2023

VERMONT
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Agency of Human Services
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Legislative Charge

Sec. 4. MENTAL HEALTH INTEGRATION COUNCIL; REPORT
(1) On or before December 15, 2021, the Commissioners of Mental Health and of Health shall report on the Council's progress to the Joint Health Reform Oversight Committee.
(2) On or before January 15, 2023, the Council shall submit a final written report to the House Committee on Health Care and to the Senate Committee on Health and Welfare with its findings and any recommendations for legislative action, including a recommendation as to whether the term of the Council should be extended.

[Complete charge and membership are provided in Appendix # 1]

Executive Summary

The Mental Health Integration Council was created by the legislature to address integration on a systems level. This requires addressing issues including the lack of focus on the promotion of mental health and prevention of mental health conditions as well as provision of holistic, integrated care in a seamless manner. These and other upstream efforts, including an emphasis on providing stigma-free, equitable care for those with serious mental illness, are the focus of the Council. An integrated system of care will put us on the path to reducing the challenging realities seen in hospitals today, improving the standard of care for patients and their families and the overall well-being and health of Vermonters.

The Council and the Workgroups will continue to meet until July of 2023. In addition to continuing the work underway (see summary below and full recommendations in Appendix #6), the Council and Workgroup members will use the remaining time to: 1) focus on system-level approaches to integration that embrace complexity and develop an appropriate evaluation methodology; 2) learn more about and discuss the development of peer services in Vermont; 3) continue to better understand the role of the Accountable Care Organization, OneCare, and payment reform in furthering integration.

Interim Recommendations

The Mental Health Integration Council is making interim recommendations developed by its four Workgroups. The summary below represents only major points from each workgroups. The full interim recommendations can be found in Appendix #6.

The interim recommendations will be further defined in the final report of the Council.

Recommendation of the Integration of Primary Care Workgroup

1. Pursue implementation of a mental health peer or community health worker in a primary care practice as a single point of entry that is person-centered, equity-based, and wellness-focused and provided in accordance with Vermont's laws regarding parity.

Recommendation of the Integration of Pediatric Care Workgroup

1. Incentivize with resources (financial and implementation assistance) the integration of mental health within primary care serving child, youth, and family through pediatric-specific applications of the locally selected integrated care model(s) to ensure wellness, rather than focusing on responding to problems.
2. Increase integration of healthcare in Coordinated Services Planning for children and youth with disabilities.

Recommendation of the Integration of Funding & Alignment of Performance Measures Workgroup

1. Conduct a formal needs assessment to assess the parity of covered services by Vermont's health insurance payers, and the use of performance measures across health care providers and organizations, state government entities, and health insurance payers.

2. Pilot selected integration care models using rigorous improvement science methodology in order to study the effect on health care delivery funding and any improvement on established performance measures.

Recommendation of the Integration of Workforce Development Workgroup

1. Align with the work of the Health Equity Advisory Commission
2. Identify opportunities for shared or leveraged staffing through contracting with Federally Qualified Healthcare Centers (FQHCs), Designated Mental Health Agencies (DAs) and exploring the potential for Certified Community Behavioral Health Clinics (CCBHCs)
3. Explore how care may be "best served" at a Designated Mental Health Agency (or a CCBHC) or an FQHC
4. Develop guiding principles for Workforce Development

Introduction

The charge to the Mental Health Integration Council, formed as a result of legislation passed in 2020, is to help "to ensure that all sectors of the health care system actively participate in the State's principles for mental health integration." That charge essentially challenged the Department of Mental Health and its partners to collaborate on moving toward truly integrated health care. Yet the Council is not the first attempt - in Vermont, nationally or even internationally - to make mental health care part of "care as usual." By some counts, there have been three decades of attempts to integrate care. In Vermont, we have at times led the nation in our efforts to integrate care by responding quickly to new federal funding or regulatory support, devising our own payment reforms, and embracing promising new care models.

Why, then, is care not integrated across all providers, everywhere in Vermont? Systems change research argues such efforts fail when the traditional step-by-step, top-down approach is used. In other words, we have treated integration as a complicated problem that can be solved by laying out a series of logical steps and then directing the implementation of those steps much as we do for any project. We name the problem and charge a person or department with directing the work to solve the problem. We may invest large amounts of money to identify the critical pieces that must be addressed, create a logic model or other organizing structure to order how and when we address each critical piece, and put a great deal of time and effort into trying to realize the outcomes identified in the model.

Those who study systems change, however, argue that the top-down approach ignores the nature of what we are trying to change. Health systems are "open systems with fuzzy boundaries comprised of numerous, diverse and highly interactive agents[i]." Given the constant, unpredictable adaptations taking place in various settings with diverse clients/patients and providers, in a context of changing payment, health records and data structures, a "command and control" approach to changing how service is provided is ineffective.

In addition to the provider side of the equation, there is the vast diversity of clients, patients and the general public to consider. This variability becomes clear when we think about the ideal providers and patients/clients envisioned in a guideline or quality improvement algorithm and the actual human beings involved in providing care and in seeking care. As a result, planning precise steps for change initiatives is unrealistic.

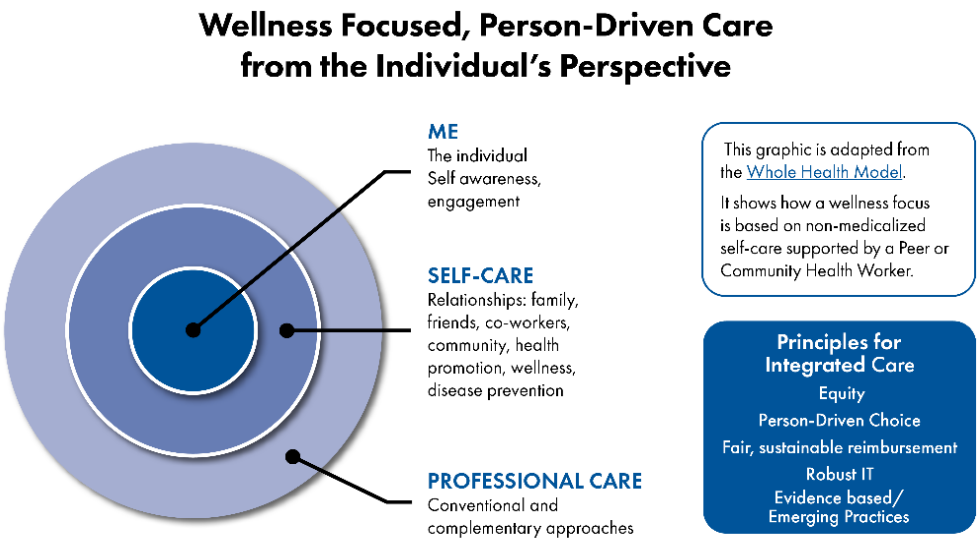
Researchers have found that successful integration of care requires everyone who works in and helps determine how care is provided to deeply understand all aspects of health care systems. There must be time for building relationships and sharing information and the people in those discussions must be reimbursed for their time. Interprofessional teamwork, in other words, is fundamental, as are shared financial systems[ii]. Engagement of all participants in integration work is key. Performance measurement and reporting must be transparent, system-level cost management and quality outcomes must be rewarded, and accountability shared. Critically, the process of integration must be recognized as a learning process that evolves, rather than a series of programmatic steps.

This is the work that the Council and additional members of four Workgroups (more on the Workgroups, below) have been engaged in over the past 18 months. The meetings have been designed to allow the members and other participants to build relationship; rather than reviewing many integration models, the focus has been on understanding of concepts and agreement on principles of integration. The Council has agreed on a draft vision of integrated care, and the workgroups have begun work on aspects of that vision.

What is "Integrated Care?"

What does "integrated care" mean? Does it mean that mental health clinicians are "co-located" within a primary care practice? Does it mean that medical services providers are "co-located" within a mental health clinic? Or does each type of practice hire its own staff from the different professions? The many integration models used across the country reflect the various possibilities under the label "integrated." The Council compiled an inventory of models that are either used in Vermont or have drawn the interest of providers on the Council or in the Workgroups. To date, the Council has heard specifically about four methods of providing some level of integrated care – Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, Whole Health Model and the AIMS or Collaborative Care Model.

As the Council and Workgroup members discussed these methods and integration in general, it became clear that time constrictions alone meant every model identified could not be explored in-depth. More significantly, the Council agreed that since models overlap in many ways, and that no model is implemented exactly as designed, examining more than a few representative models seemed redundant.



Instead, the Council and Workgroup members named what integration should be. The Funding & Alignment of Performance Measures Workgroup said that integrated care would mean that "Vermonters easily…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 Council has said that Vermonters seeking care should have whole-health support. To this end, the Primary Care Workgroup will explore having an embedded, trained staff person available to all who seek care. This staff person will be able to help address social and racial disparities in health care and provide support for health and wellbeing, by listening to and/or helping the individual to identify their concerns, hopes and goals – if the person seeking care wants that support. In addition, there is general agreement on the Council that care and services and how they're provided and accessed must be flexible. As discussed in a 2001 publication of the Institute of Medicine[iii], "flexible" means schedules for when and where services are available might change given demand.

Even the kinds of care and services could change. For example, in a truly flexible system the care and services that are reimbursed may be different in one practice than another.

And rather than identifying practice models, the Council and Workgroup members agreed on a set of principles that should guide integrated care. The members agreed that no matter how care is integrated, it must be based in equity, person-driven care with choice, have fair sustainable reimbursement, robust IT and evidence-based/emerging practices. Whether from the systems-level or in a practice, integrated care, as considered by the Council, must adhere to these principles.

Council members agree that there are many examples of care in Vermont that fall somewhere along the spectrum of integrated care. There are designated mental health agencies that have memoranda of understanding with local primary care offices to ensure that clients have a primary care provider. There are primary care practices with mental health professionals on staff or at least "co-located."

Vermont has 13 Federally Qualified Health Centers operating in 44 locations, and all either provide mental health services or are parties in memoranda of understanding that establish referral pathways to their community mental health agency. The University of Vermont Health Network, which employs more than 600 physicians and offers services through seven locations across Vermont and northern New York state, is implementing an integration model with the goal that "all advanced primary care should include full, easy on-site and telehealth access to mental health services, behavior change counseling for chronic disease management, and substance use disorder care including screening, medication-assisted treatment and counseling." Four Designated Mental Health Agencies are either implementing or in the planning stages for implementing the Certified Community Behavioral Health Clinic model. And the Veteran's Administration (VA) in White River Junction developed an approach to integration that became national VA policy 15 years ago. More recently, the VA model of integrated care has become the platform for the VA's evolution to a patient-driven Whole Health model of care.

But these examples are making some level of integration work in spite of systems-level payment, staffing and other structures that are built for divided care, instead of with the support of a system built for integration. There are the significant and challenging issues of workforce training and development, data collection and the sharing of highly sensitive, personal health information among providers, emergency care, pediatric care, elder care, prevention, and public health.

It must also be said that even in those locations where health care is integrated to some extent, there often remain fundamental disagreements in how care is provided, from "overmedicalizing" mental health conditions on the one hand to failing to address issues most important to patients in a comprehensive and rigorous manner on the other.

These are some of the reasons that even after nearly three decades of effort to integrate the care of mental health with medical care, too many Vermonters continue to receive mental and other health care in offices or locations that have little interaction with – or even knowledge of – the care provided by their "counterparts."

In short, the concept of integration – meaning that the patient or client receives the care, or in the case of public health, the information, or other resources they need where they need it - is complex.

A Complex Case

A significant body of research[iv] indicates that it is this complexity that must be addressed. Rather than focusing on the discrete complications of separate care, distinct practice cultures and patient/client variability to further integration, we must approach change through a lens of complexity. The members of the Council and Workgroups have repeatedly named many of the fundamentals of taking a complex approach to integration, including avoiding a one-size-fits-all approach, taking a proactive and whole-person approach to people's health, and understanding and including the diversity of patients/clients.

A common sentiment is reflected in the Funding & Alignment of Performance Measures Workgroup statement: "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. …Whatever we do can't be a rigid one-size-fits-all approach. How do you [pay]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[v]."

Through-out the time the Council and Workgroups have been meeting, there have been suggestions that the Council address the problem of people experiencing psychosis or suicidal ideation who too often wait in hospital emergency Departments for long periods of time to receive care. While this is a critical issue, there are concerted efforts led by DMH to address the acute need. The Council was directed to address integration on a systems level – indeed, to address issues such as a lack of focus on the promotion of mental health and prevention of mental health conditions, as well as provision of care in a seamless manner, that could result in fewer people reaching a crisis state and seeking care in an emergency department. These and other upstream impacts, including an emphasis on providing stigma-free, equitable care for those with serious mental illness are the focus of the Council. An integrated system of care will put us on the path to reducing these challenging realities seen in hospitals today.

Council and Workgroup members have consistently stressed that we need more than "just treatment planning." Truly integrated care would approach people with a broad perspective that considers the context of their lives. For example, while a provider may be concerned that the person is dealing with anxiety or their diabetes management is poor, helping them secure food for their children may be the first step to helping resolve the "presenting condition." Providers

Comments[vi] from Primary Care Workgroup members represent Council and Workgroup suggestions about how to achieve integrated care. Minor editing has been done for clarity.

"How are [we] working…to promote equity and cultural sensitivity in policies?"

"We should be thinking about the way we collect data—and …think of data differently."

"We talk about encouraging hiring from a variety of backgrounds…. We should have people on hiring teams who represent the groups you are hoping to recruit from."

"Unless the people who are most impacted by the policies are a part of all the work and informing what happens, the work doesn't move forward in the best way."

"We need to create our culture. [It is about] learning and moving forward and it is a journey. It's about the process to get there."

should seek to understand the individual's priorities and support them in achieving those priorities.

The points made by the Council and Workgroup members agree with the research that identifies the elements that must be embraced to effect change in a complex system. A report from the Institute of Medicine lays out 10 "simple rules" (see box, and in Appendix # 3, an example of how the rules change practice), similar to what Council and Workgroup members have identified as necessary for person-driven, whole-person health promotion and care.

Simple Rules

Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

1. **Care based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.
2. **Customization based on patient needs and values.** The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
3. **The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. **Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. **Evidence-based decision making.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. **Safety as a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors. 7. The need for transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. **Anticipation of needs.** The health system should anticipate patient needs, rather than simply reacting to events.
9. **Continuous decrease in waste.** The health system should not waste resources or patient time.
10. **Cooperation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Institute of Medicine 2001. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: The National Academies Press. https://doi.org/10.17226/10027

These rules give providers direction within certain boundaries regarding specific resources, as well as permission to innovate. Working from these basic guidelines, the interprofessional teams can support practice-based learning and identify areas for change and improvement, with the continuous and explicit input of patients, clients and community partners. The goals that are established and resources that are secured are all based on a view of the whole system rather than parts of the system[vii].

The Workgroup Products

The Council is comprised of 23 members as detailed in the legislative charge (see Appendix #1)

Appropriately, the Council members are commissioners of state departments, the director of health care reform, members of the Green Mountain Care Board, CEOs or directors of partner agencies, members of advocacy groups or people with lived experience. While the members have been engaged in the meetings, however, few have time

to do the work between meetings that is intended to initiate or support efforts to integrate care. In order to facilitate such efforts, the Council invited others to join one of four workgroups (see Appendix #2). The Workgroups are Primary Care, Pediatric Care, Funding & Alignment of Performance Measures and Workforce Development. Details of their work over the past 18 months can be found in Appendix #6.

Briefly, the Workgroups have spent many hours doing the work of relationship building and defining the parameters of the issues they are discussing. The range of results from the four Workgroups accurately reflects the complexity of integration. The Pediatric Care Workgroup has laid out a draft of a project in detail; the Primary Care Workgroup, co-facilitated by a Blueprint for Health Director, agreed to focus on implementation of the use of a trained, embedded staff person who can provide support regarding social contributors to health. The Funding & Alignment of Performance Measures is considering the potential uses of an assessment of how parity laws function in Vermont and where support or other action might be needed. And the Workforce Development group has been discussing how to share staffing and other resources to ensure Vermonters can get appropriate treatment and care when and where they need it.

Interim Recommendations

The Council and its Workgroups will continue to meet until July of 2023. In addition to continuing the work underway in the Workgroups (see summary below), the Council and Workgroup members will use the remaining time to: 1) focus on system-level approaches to integration that embrace complexity and develop an appropriate evaluation methodology; 2) learn more about and discuss the development of peer services in Vermont; 3) continue to better understand the role of the Accountable Care Organization, OneCare, and payment reform in furthering integration.

Summary of Workgroup Recommendations

Recommendation of the Integration of Primary Care Workgroup

1. Vermonters seeking care should have whole-health support. An embedded staff person who can help address social and racial disparities in health care and provide support for health and well being should be made available to all.
2. Explore expanded use of Recovery Coaches and strengthening ties with Substance Use systems
3. Ensure all care is trauma-informed and equity-based

The Workgroup will pursue implementation of placing a peer or community health worker in a single primary care practice as a single point of entry that is non-medical, equity-based and wellness-focused.

Recommendation of the Integration of Pediatric Care Workgroup

1. Incentivize with resources (financial and implementation assistance) the integration of mental health within primary care serving child, youth and family through pediatric-specific applications of the locally selected integrated care model(s) to ensure wellness, not just reaction to problems.
2. Increase integration of healthcare into Coordinated Services Planning structures to support coordinated care for children and youth with disabilities.

Recommendation of the Integration of Funding & Alignment of Performance Measures Workgroup

1. Conduct a formal needs assessment to assess parity and the use of performance measures across health care providers and organizations, state government entities, and health insurance payers.
2. Pilot selected integration care models in different health care settings applying rigorous improvement science methodology to study the impact on health care delivery funding and any improvement on established performance measures.

Recommendation of the Integration of Workforce Development Workgroup

1. Align with the work of the Health Equity Advisory Commission
2. Examine opportunities for shared or leveraged staffing through contracting with entities like Federally Qualified Healthcare Centers (FQHCs), Designated Mental Health Agencies (DAs) and Certified Community Behavioral Health Clinics (CCBHCs)
3. Explore how care may be "best served" at a DA, a CCBHC or an FQHC
4. Develop guiding principles for Workforce Development

End Notes

[i] *Tsasis, P. et. al, Reframing the challenges to integrated care: a complex-adaptive systems perspective, 18 September (Volume 12): International Journal of Integrated Care2012 ;* https://pubmed.ncbi.nlm.nih.gov/23593051/

[ii] Tsasis, P. et. al. https://pubmed.ncbi.nlm.nih.gov/23593051/; Plesk, Paul E., et. al. *Complexity, leadership, and management in healthcare organisations, BMJ 2001;323:746 https://www.bmj.com/content/323/7315/746.1 ; Allana, A ,'Building integrated, adaptive and responsive healthcare systems – lessons from paramedicine in Ontario, Canada, (Volume 22): BMC Health Services Research2022 ; https://tinyurl.com/ykxxz5me*

[iii] Institute of Medicine 2001. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: The National Academies Press. https://doi.org/10.17226/10027

[iv] Braithwaite et al. BMC Medicine (2018) 16:63 https://doi.org/10.1186/s12916-018-1057-z; Qual Saf Health Care 2006;15:85–88. doi: 10.1136/qshc.2005.014605 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464825/ Khan, S., Vandermorris, A., Shepherd, J. et al. Embracing uncertainty, managing complexity: applying complexity thinking principles to transformation efforts in healthcare systems. BMC Health Serv Res 18, 192 (2018). https://doi.org/10.1186/s12913-018-2994-0 Greenhalgh, T., Papoutsi, C. Studying complexity in health services research: desperately seeking an overdue paradigm shift. BMC Med 16, 95 (2018). https://doi.org/10.1186/s12916-018-1089-4 Churruca K, Pomare C, Ellis LA, et al The influence of complexity: a bibliometric analysis of complexity science in healthcare BMJ Open 2019; https://bmjopen.bmj.com/content/9/3/e027308

[v] https://tinyurl.com/y6ys6tpf

[vi] https://tinyurl.com/zwcw9rwj

[vii] *Plsek, Paul E., Wilson, Tim, Complexity, leadership, and management in healthcare organisations. BMJ 2001;323:746–9*

Appendix 1 - Full Legislative Charge and List of Members

No. 140. An act relating to miscellaneous health care provisions

Sec. 4. MENTAL HEALTH INTEGRATION COUNCIL; REPORT

Creation. There is created the Mental Health Integration Council for the purpose of helping to ensure that all sectors of the health care system actively participate in the State's principles for mental health integration established pursuant to 18 V.S.A. § 7251(4) and (8) and as envisioned in the Department of Mental Health's 2020 report "Vision 2030: A 10-Year Plan for an Integrated and Holistic System of Care."

The Council shall address the integration of mental health in the health care system, including:

1. identifying obstacles to the full integration of mental health into a holistic health care system and identifying means of overcoming those barriers;
2. helping to ensure the implementation of existing law to establish full integration within each member of the Council's area of expertise;
3. establishing commitments from non-state entities to adopt practices and implementation tools that further integration;
4. proposing legislation where current statute is either inadequate to achieve full integration or where it creates barriers to achieving the principles of integration; and
5. fulfilling any other duties the Council deems necessary to achieve its objectives.

The Council may create subcommittees comprising the Council's members for the purpose of carrying out the Council's charge.

The Commissioner of Mental Health shall call the first meeting of the Council.

(2) The Commissioner of Mental Health shall serve as chair. The Commissioner of Health shall serve as vice chair.

(3) The Council shall meet every other month between January 15, 2021 and January 1, 2023.

(4) The Council shall cease to exist on July 30, 2023.

On or before December 15, 2021, the Commissioners of Mental Health and of Health shall report on the Council's progress to the Joint Health Reform Oversight Committee.

On or before January 15, 2023, the Council shall submit a final written report to the House Committee on Health Care and to the Senate Committee on Health and Welfare with its findings and any recommendations for legislative action, including a recommendation as to whether the term of the Council should be extended.

If applicable

Mental Health Integration Council members, as required by the legislative charge

(A) the Commissioner of Mental Health or designee; **Alison Krompf, Deputy Commissioner**

(B) the Commissioner of Health or designee; **Mark Levine, Commissioner**

(C) the Commissioner of Vermont Health Access or designee; **Sandi Hoffman, Deputy Commissioner**

(D) the Commissioner for Children and Families or designee; **Geoffrey Pippenger, Director of Policy & Planning**

(E) the Commissioner of Corrections or designee; **Annie Ramniceanu, Executive Director of Mental Health and Addiction Services**

(F) the Commissioner of Disabilities, Aging, and Independent Living or designee; **Monica White, Commissioner**

(G) the Commissioner of Financial Regulation or designee; **Michael Pieciak, Commissioner**
(H) the Director of Health Care Reform or designee; **Ena Backus, Director of Health Care Reform**
(I) the Executive Director of the Green Mountain Care Board or designee; **Susan Barrett, Executive Director**
(J) the Secretary of Education or designee; **Heather Bouchey, Deputy Secretary**
(K) a representative, appointed by the Vermont Medical Society; **Dr. Simha Ravven**
(L) a representative, appointed by the Vermont Association for Hospitals and Health Systems; **Devon Green & Emma Harrigan**
(M) a representative, appointed by Vermont Care Partners; **George Karakabakis, CEO, Health Care & Rehabilitation Services**
(N) Vermont Association of Mental Health and Addiction Recovery representative; **Vini Emery**
(O) a Bi-State Primary Care representative - **Mary Kate Mohlman, Director Vermont Public Policy; Michael Costa, CEO Northern Counties Health Care**
(P) a University of Vermont Medical School representative; **Dr. Christian Pulcini**
(Q) the Chief Executive Officer of OneCare Vermont or designee; **Dr. Carrie Wulfman**
(R) the Health Care Advocate - **Mike Fisher**
(S) the Mental Health Care Ombudsman - **Lindsey Owen & Zachary Hozid**
(T) a representative, appointed by the insurance plan with the largest number of covered lives in Vermont; BCBS; **Dr. Tom Weigel**
(U) two persons who have received mental health services in Vermont, appointed by Vermont Psychiatric Survivors, including one person who has delivered peer services; **Karim Chapman & Dan Towle**
(V) one family member of a person who has received mental health services, appointed by the Vermont chapter of National Alliance on Mental Illness; **Ward Nial**
(W) one family member of a child who has received mental health services, appointed by the Vermont Federation of Families for Children's Mental Health; **Sandi Yandow**

Appendix 2 - Workgroups and their Membership

Workgroups and their Membership

Other than the facilitators, membership varies due to individual availability, so all lists may be subject to change.

Integration of Primary Care

Facilitators

Julie Parker, Assistant Director, Blueprint for Health, Department of Vermont Health Access
Samantha Sweet, Mental Health Services Director, Department of Mental Health

Members

Will Eberle, MPA, Executive Director, Recover Vermont, Vermont Association of Mental Health and Addiction Recovery
Vini Emery, (former) Program Manager: Recovery Coaches in the Emergency Department, Recovery Vermont
George Karabakakis, Chief Executive Officer, Health Care & Rehabilitation Services of Southeastern Vermont
Kate LaRose, Child, Adolescent and Family Unit, Department of Mental Health
Alexis McGinnis, family advocate, person with lived experience, member DMH Adult Standing Committee
Mary Kate Mohlman, Vermont Director of Public Policy, Bi-State Primary Care Association
Health Network
Andrew S. Pomerantz, MD, retired psychiatrist and primary care provider
Former national director, integrated services, Office of Mental Health and Suicide Prevention, Veterans Health Administration,
Cynthia Seivwright, MA, LCMHC, Director, Substance Use Programs, Vermont Department of Health
Dan Towle, MBA, President and Founder Parker Advisors, LLC
Christine Werneke, Network Director of Integration & Strategy, UVM Health Network Medical Group

Integration of Pediatric Care

Facilitators

Laurel Omland, Director, Child, Adolescent & Family Unit, Department of Mental Health
Dr. Haley McGowan, Children's Medical Director, Department of Mental Health

MEMBERS

Heather Bouchey, Deputy Secretary, Agency of Education
Dillon Burns, Mental Health Services Director, VT Care Partners
Mike Fisher, Office of the Health Care Advocate
Emma Harrigan, Director of Policy Analysis and Development, Vermont Association of Hospitals & Health Systems
Dr. Logan Hegg, UVMMC psychologist, pediatric integration
Dr. Breena Holmes, UVM, VT Child Health Improvement Program
Ward Nial, Representative, National Alliance on Mental Health
Dr. Sara Pawlowski, UVMMC psychiatrist, pediatric integration
Dr. John Saroyan, Executive Director, Blueprint for Health
Connie Schutz, VT Department of Mental Health, CHILD grant (grant ended 9/30/2022)
Ilisa Stalberg, VDH Maternal Child Health
Sandi Yandow, Executive Director, Vermont Federation of Families for Children's Mental Health

Special thanks to **Andrea Van Liew** and **Jeanette Romkema** of Global Learning Partners (GLP). They not only modeled the learning-centered approach in all they do but they also facilitated a rich and important process for the Pediatric Subgroup to develop its report and recommendations.

Integration of Funding & Alignment of Performance Measures

Facilitators

Stephen DeVoe, Director of Quality & Accountability, Department of Mental Health
Ena Backus, Director of Health Care Reform, Agency of Human Services

Members

Sebastian Arduengo, Assistant General Counsel, Department of Financial Regulation
Susan Barrett, J.D., Executive Director, Green Mountain Care Board
Josiah Mueller, RN, BSN, MHS, Director of Value Based Care, OneCare Vermont
Michael Hartman, Chief Executive Officer, Lamoille County Mental Health Services
Bard Hill, Principal Assistant, Department of Disabilities, Aging, and Independent Living (now retired)
Lindsey Owen, Executive Director, Disability Rights Vermont
Geoffrey Pippenger, Director of Policy and Planning, Department for Children and Families
Julie Zack, Director, Integrated Health, Blue Cross Blue Shield Vermont

Integration of Workforce Development

Facilitators

Alison Krompf, Deputy Commissioner, Department of Mental Health
Kheya Ganguly, Director of Trauma Prevention and Resilience Development, Department of Mental Health

Members

Devon Green, Vice President of Government Relations, Vermont Association of Hospitals and Health Systems
Mary Kate Mohlman, Vermont Director of Public Policy, Bi-State Primary Care Association
Julie Tessler, Executive Director, Vermont Council of Developmental and Mental Health Services/Vermont Care Partners
Dan Towle, MBA, President and Founder Parker Advisors, LLC

A special thank you is due to **Maureen McKenna**, of **Return on Energy**, a strategic partner of **Spartina Consulting**. Her guidance and wisdom provides essential grounding for the work of the Council.

Appendix 3 – Institute of Medicine's Ten Simple Rules

Institute of Medicine's 10 Simple Rules for Guiding for person-driven, whole-person health promotion and care. An example is shown, below, of how the Simple Rules may play out in practice.

Simple Rules for The Design of the 21st Century Healthcare System in the United States

Traditional Approach	New Rule
Care is based primarily on visits	Care is based on continuous healing relationships
Professional autonomy drives variability	Care is customized according to patients' needs and values
Professionals control care	The patient is the source of control
Information is a record	Knowledge is shared and information flows freely
Decision making is based on training and experience	Decision making is evidence based
"Do no harm" is an individual responsibility	Safety is a system property
Secrecy is necessary	Transparency is necessary
The system reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continually decreased
Preference is given to professional roles over the system	Cooperation among clinicians is a priority

Source: Institute of Medicine Committee on Quality of Health Care in America

Appendix 4 – Principles

1. **Equity**
   Social Contributors to Health

2. **Patient choice/patient driven (vs. "patient centered")**
   "Care where people live, work, and play"

   Importance of mobile crisis services

   Family/child/youth focus where appropriate

   Lifespan approach

   Wellness focus (not disease focused)

   Peer support

   Care coordination (with coordination among the coordinators!) – need fair reimbursement, on-going training, workforce development ("they're swimming in a sea of vagueness.")

   Do not medicalize mental health

   Caregiver support/outreach for homebound

3. **Appropriate and Sustainable reimbursement, with ease of providing care regardless of insurance**
   Focus on collaboration and not focusing on competition/fighting for limited resources

   Medicare issues –

   1) Private mh providers can't bill. Yet we have one of the oldest populations in the country (needs are great).
   2) Insufficient coverage overall, too complex.

4. **Robust IT**
   Safety/security for IT/EHRs

   IT Infrastructure/Health Information Exchange – patient no longer provides same info repeatedly

   Data management – observe and measure clearly; equity issues

5. **Evidence-based/emerging practices**

   Achieve quality without limiting innovation
   Equity issues

Appendix 5 – Inventory of Integrated Care Models

This is not an exhaustive list, and the notes for each model are not exhaustive.

Model

Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework

- Addresses patient/family level
- a conceptual framework for using family-centered care as a launch pad for pursuing "integrated family care"—systematically ensuring that all family members' health needs are met through effective, seamless, and integrated services

Advantages

- Family-Centered Care - a way of organizing care to ensure family members are shared decision-makers in health care
- Bridging Efforts - builds toward integrated family care by inquiring about–and offering interventions or referrals for– priority family health concerns
- Integrated Family Care - a way of organizing care to ensure all family members' health needs are met through effective, seamless, and integrated services
- Aims to maximize insurance coverage with continuous enrollment policies for parents, pregnant women, and children
- Builds on Patient Centered Medical Home model

Challenges

- "Integrated family care" goal requires significant shift in how providers and payers view families
- Requires transformation of health care delivery structures and payment incentives that encourage family-based approaches and reduce silos between care for family members

AIMS - Ambulatory Integration of the Medical and Social

(Different from the University of Washington model, below)

Focused on

- Patient/Caregiver engagement
- Assessment & care plan development
- Telephonic or in-person case management
- Goal attainment
- Ongoing care

Advantages

- AIMS social worker contacts the patient/caregiver to explain the intervention and schedule full assessment
- Goal of the contact to develop rapport and trust, ensure the patient/caregiver understands the rationale for the intervention, and begin to identify issues the patient /caregiver feels are important
- AIMS social worker performs a standardized comprehensive biopsychosocial assessment with a focus on strengths and barriers in multiple domains including finances, functional abilities, cognition, mental health and many others
- Care plan goals developed collaboratively with patient/caregiver using motivational interviewing techniques in order to select one to three person-centered goals based on complexity, safety concerns, and the patient/caregiver's ability to independently work on a goal
- If goals are not attained, the AIMS social worker will problem-solve using motivational interviewing techniques and psychoeducation.
- If continued social work intervention regarding Care Plan agreed upon goals is warranted, the social worker and client with reevaluate care plan and reengage in active case management.

AIMS - Advancing Integrated Mental Health Solutions (AIMS, University of Washington)

The University of Vermont Health Network is implanting this model.

This is a Collaborative Care Model (CoCM) developed at the University of Washington.
Five core principles define Collaborative Care and should inform every aspect of an implementation.

1. Patient-Centered Team Care
2. Population-Based Care
3. Measurement-Based Treatment to Target
4. Evidence-Based Care
5. Accountable Care

Advantages

The AIMS Center has extensive implementation resources, online guide, tools, and training to support integration.

Challenges

- Lacking all necessary service elements, particularly onsite PCP's, within a given organization
- May require community organization staff to carry multiple responsibilities
- May overburden part-time community organization staff
- May overburden social workers, care managers, and psychiatrist participants with care manager functions when added to existing responsibilities - need dedicated care manager, or share care management tasks among several staff (which has its own challenges)
- Requires infrastructure such as office space and protected time to meet with clients/patients
- Requires consistent buy-in and support from different levels within the organization
- Requires changes to existing organization structure and culture of care
- In one study, clinicians did not consistently use protocols within the collaborative care model, use screening tools, or update the team about patient status as care progressed.

- May challenge provider expectations about what is, or is not, within scope of care and clinical responsibility.
- Maintaining patient engagement

BCBS-Vermont and Brattleboro Retreat: Vermont Collaborative Care (VCC)

This is a partnership between BCBSVT and the Brattleboro Retreat to provide case management for mental health and substance use disorders to BCBS-VT members.

Advantages

Leverages payer-provider relationship to provide better outcomes, lower cost and improve patient and clinical experiences (quadruple aim). This relationship also enables VCC to deliver other value-based services such as Feedback Informed Treatment support for therapists, in-home services for youth in crisis (Howard Center and HCRS), and wilderness therapy through True North in Waitsfield.

Challenges

None identified

Blueprint for Health

This model is implemented state-wide in all Blueprint practices, which include more than 300,000 patients. The Blueprint is a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.

Advantages

As of February 2022, there were 305,854 patients attributed to Blueprint practices. Of those,
285, 404 insurer-attributed patients
96,447 Medicaid-attributed patients
135 recognized Patient Centered Medical Homes
170 Core Community Health Team FTEs
Includes Hub & Spoke, Women's Health Initiative, Community Health Teams
Operates under the All-Payer model"

CCBHC - Certified Community Behavioral Health Clinic

The Clara Martin Center in Randolph is in its second year of implementation of this model. Three more designated mental health agencies received federal grants to support planning for implementation of the CCBHC model. They are Northeast Kingdom Human Services in Newport, Health Care and Rehabilitation Services in Springfield, and Rutland Mental Health Services Agency in Rutland.

CCBHC's are designed to provide a comprehensive range of MH and substance services, particularly to vulnerable individuals with the most complex needs emphasizing recovery, wellness, trauma-informed care, and physical-behavioral health integration. CCBHC's must provide nine core services: crisis mental health services, screening/assessment/diagnosis, patient-centered treatment planning, outpatient MH/SUD services, primary care screening and monitoring, targeted case management, psychiatric rehabilitation services, peer supports, services for veterans and members of the armed services.

This is a national model of care delivery supported by the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) which allows for enhanced reimbursement under the demonstration program. Vermont has the option of maintaining CCBHC services under the 1115 waiver or State Plan Amendment in lieu of demonstration status.

Advantages
Allows for expanded coordination with other healthcare and social service providers, with a focus on whole health and comprehensive access to behavioral, medical, and supportive services; serves any individual in need regardless of ability to pay or location of residence; supports electronic information exchange amongst providers and integration of EHR's where practicable; reduces barriers to care and provides for flexible care delivery models

Challenges
Increases reporting burden on mental health agencies
Funding source not clear once grant funds and state Medicaid exhausted

CCM - Chronic Care Model is implemented as the Vermont Chronic Care Initiative

The Vermont Chronic Care Initiative (VCCI) provides holistic, intensive, and short-term case management services to Vermont residents enrolled in Medicaid, including dually eligible members. VCCI works with members referred for complex case management by healthcare and human services providers, state colleagues and partners, as well as through care management predictive modeling methodology. VCCI case managers and outreach coordinators also welcome members new to Medicaid (NTM), and screen members to identify and prioritize needs.

Screening tools explore issues regarding access to care (including primary and dental), the presence and status of health conditions, and inquire about other needs that would assist the person to maintain and/or improve their health, such as housing, food and safety.

The VCCI team works to connect members with medical homes, community-based self-management programs, local care management teams and help members to navigate the system of health and health related care.
The VCCI uses common tools and processes adopted by the local community care teams as part of the complex care model to include eco mapping, identification of lead care coordinator, facilitating care teams, and shared care plan development.
Licensed case managers trained in the complex care model, deliver services in communities throughout the state.

CCM - Collaborative Care Model

The AIMS model out of University of Washington (above) is based in the Collaborative Care Model. That model is being implemented by UVMHN.

DULCE - Developmental Understanding Legal Collaboration for Everyone

This model is implemented at the Lamoille Family Center, Morrisville, OneCare practices (Timberlane Pediatrics Milton; Timberlane Pediatrics South Burlington; Springfield Area Parent Child Center, The Family Place at Ottauquechee Health Center) and Mt. Ascutney Hospital and the Orange County Parent Child Center, and more.

DULCE is incorporated into clinical practice for families of infants birth to six months. The DULCE Family Specialist is teamed with the provider at all well-child visits and helps connect patients and their family members to concrete supports in the community, therefore extending the medical care provided. The Family Specialist asks families about social needs and issues like maternal depression, which the American Academy of Pediatrics considers critical to the pediatric well-child visit

The DULCE family specialist "extends the medical visit beyond the exam room." The DULCE family specialist also works to ensure consistent messaging and warm hand-offs should the family continue to receive services beyond the infant's six-month birthday.

Uses the Strengthening Families/Youth Thrive framework

FQHC - Federally Qualified Healthcare Center

Health centers are community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and veterans.

Patient-Centered Medical Home

Health centers integrate access to pharmacy, mental health, substance use disorder, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care. By emphasizing coordinated care management of patients with multiple health care needs and the use of key quality improvement practices, including health information technology, health centers reduce health disparities.

Advantages
• Assigns patients to primary care physicians, ensuring patients know who is responsible for their health and providers know the patients they are responsible for.
• PCMH as "gate-opener" - does not manage or limit access. Actively coordinates people to most appropriate care.
• Much care delivered by multidisciplinary teams in primary care
• Specialist care services are purchased by the primary care team on behalf of the patient.
• PCMH employs the principles of shared responsibility for a patient's health
• Information technology and health information exchanges play important role ensuring patients get indicated services when and where they need it in a culturally and linguistically appropriate manner

Challenges
"Reddy et al[1] examined the association of longitudinal changes in PCMH implementation with 3 high-cost health care utilization outcomes: emergency department (ED) visits, hospitalizations for ambulatory care–sensitive

conditions (ACSCs), and all-cause hospitalizations. They found no consistent association of more robust PCMH implementation with better outcomes."
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760021

One Location, One Visit: Pediatric Integrated Health Care Implementation Model

Implemented at CHILD sites (SAMHSA-funded) in Franklin Co, Springfield, Washington Co, Rutland

Model integrates mental health and medical care for children and deploys a behavioral health consultant (BHC)

Advantages
Pediatric-specific focus largely based on the AIMS Center (UW) framework. Implementation guide details & tools covering process for engaging all stakeholders in change process, development of procedures and workflows, description of positions/roles, evaluation & monitoring strategies

Challenges
None identified

Well-Being Measures Framework

Cross-sector measures to drive collaborative improvement in population health, address social determinants and equity, and improve the health and well-being of people and communities

Whole Health Model

Model originated and its components are implemented by the Veteran's Administration

Advantages
The individual drives their care. Works with a peer/health coach to identify their mission, aspirations and purpose and creates a personal health plan. Strong engagement of patient/client. As designed, peer support is central to this model, although implementer could change "peer" to health coach, care navigator, etc.

Challenges

Primary Care Providers may feel "sidelined" given strong focus on patient process to create personal health plan with strong focus on wellness (non-clinical aspects)

Appendix #6 – Workgroup Products

Integration of Primary Care Workgroup

A topic of concern the members of the Primary Care Workgroup wanted to address in detail was the perceived long wait time in emergency departments for people experiencing a mental health crisis. We reassured the group that this specific topic was being addressed in other key stakeholder groups, and that the Council's task is to help "to ensure that all sectors of the health care system actively participate." We shifted away from this conversation and began discussing the use of a tool to support goal setting and brainstorming on how we could have an effect on Primary care.

We used the SMART Goal (Specific, Measured, Achievable, Relevant and Time-bound) process in order to organize thoughts regarding an attainable goal for integration of care. This led to discussions about health promotion and disease prevention. We discussed how to address issues of stigma and normalize care-seeking for mental health conditions in any setting. We all agreed there should be no wrong door. The group considered a public health campaign on this topic. After a presentation by the Vermont Department of Health's communications division, however, it became clear that such a project would take years and a significant investment to launch. The group continued to seek ways to improve how care is provided for all Vermonters, no matter the reason they see a provider of any health-related services.

In March of 2022, the Council took part in a discussion about the Whole Health Model, which is a holistic, integrated care model developed by practitioners at the Veteran's Administration center in White River Junction. That model is based on providing a non-medical person (such as the state of Georgia uses certified peers or as Vermont's Blueprint for Health employs community health workers). There was general agreement among Council and Workgroup members that this kind of model held potential for furthering integration of care while improving outcomes in many areas.

The group noted that many healthcare providers have co-located mental health clinicians from their local designated mental health agency and other staff funded by the Blueprint. Those existing relationships are highly valued and not to be lost. However, we noted there are few staff that identify as having lived experience with mental health challenges, and we began to discuss Community Health Workers and peers.

One member of our group provided a presentation about peer services. We had the Substance use and Prevention Division present on the use of recovery coaches in the community. General discussion focused on how increasing the number of people with lived experience within health services would support providers while also helping to improve social contributors of health.

Group members agreed that improving whole health outcomes is a primary goal. Cost of care needs also to be carefully considered, and "return on investment" drew in-depth discussion. Recent studies indicate that ROI may occur in as little as four years, and that returns may be as high as 6:1[1]. One group member noted that "We may see a monetary return, but it may not be in the medical sector. For example, more people holding down jobs and paying income taxes, with fewer people being homeless." The challenge of tracking such returns was noted.

The major themes that have emerged for the workgroup are

2. Supporting expanded use of Recovery Coaches and strengthening ties with Substance Use systems were identified for further exploration
1. Ensuring all care is trauma-informed
3. Exploring and testing use of Peer supports in primary care
4. Expand use of Community Health Workers
5. Training and support of CHW/Peers and how these can be integrated

As a result, the Workgroup will pursue implementation of placing a peer or community health worker in a single primary care practice as a single point of entry that is non-medical, equity-based and wellness-focused.

The notes below summarize major points of discussion within the Workgroup.

Certified Community Behavioral Health Clinics (CCBHCs)

The group considered the federal Certified Community Behavioral Health Clinic (CCBHC) model, being implemented in Vermont by the Clara Martin Center. Three more designated mental health agencies have received CCBHC planning grants – Northeast Kingdom Community Services, Rutland Mental Health Services and Health Care and Rehabilitation Services in Springfield. Group members noted concerns that

- While CCBHCs improves access, we have yet to see data showing improvement in overall health
- Need to continue to explore effects of CCBHCs regarding physical health care
- Existing value-based payment system DMH introduced in 2019 and the latest Global Commitment (Medicaid) waiver give Vermont ability to do everything CCBHCs do. Not clear that there is much to gain from CCBHC model.
- Designated mental health agencies have been doing interagency and multi-disciplinary work for years

Peer Support

The group agreed that peers are important to integration, but that how Vermont will define "peers" has yet to be finalized. HCRS, the DA in Springfield, has a long history with providing peer support, and CEO George Karabakakis reported on their program. The peer support workforce at HCRS

- Works in adult residential programs
- Can provide information to medical providers about intentional peer support
- Paid for from HCRS case rate since there are no billing codes for peer support
  - CCBHC model covers peer support
- Peers embedded in prevention coalition, crisis response, shelters and drop-in centers
- HCRS is expanding peer supports to children, youth and families' programming
- Recently hired a peer support specialist for Developmental Disabilities program
- Shares cost with town of Hartford for peer support worker with EMT crew
- Lacks number of peer support workers needed

Trauma-Informed Services

- Need trauma-informed coaches in healthcare settings
- Need part-time opportunities for individuals that have experienced trauma
- Step-by-step guidance should be available to support individuals to actively engage in healing
- Services should be available where individuals are most comfortable
- Need a place for a higher level of care for specialty
- Need a place to come back to when specialty care no longer needed
  - How do we build bridges to this care? People need to get the right care, at the right time and the right place. This helps to prevent individuals from going into crisis.
- Need more prevention work – upstream to prevent need for crisis level of care
- How link the hospitals and designated agencies
  - shared data systems
  - share staffing
  - constantly seek ways to break down barriers to coordinating care

Substance Use Services

- Recovery Coaches in the substance use world are certified
- Additional training required for specialty work (with pregnant/parenting moms, working in EDs)

- Required to have been in recovery themselves for certain period of time
- May be part-time
- Not in primary care settings currently
- Full-time unit of four employees at Division of Substance Use (VDH) supports Recovery Coaches
- Explore use of Recovery Coaches in primary care setting

Should issue of peers in primary care settings be the focus of this group? (Peers are different than Community Health Workers)

- Need for clearly defined term – what do we mean by "Peer?"
- Peers as understood by this group (people with lived experience in mental health system of care, perhaps in substance use services) are critical and essential
- Also need to ensure peers are part of a system of care where they are getting the support they need. Having a network, supervision, etc.
- Destigmatizing and addressing that mental health is a normal part of care.

If focus on peers, need to define role in medical settings (no knowledge in group of peers in Primary Care currently)

- Explore use of peers on community health teams.
  - Could make more peers available
  - May reduce stigma in these settings
- Draft Peer job description
  - lived experience
  - understanding their role
  - how to onboard
  - self-care for peers as position could be challenging, have their own network of supports
- Explore funding for Peer supports – amount, source, etc.

Key guiding principles for integrated pediatric health care include consideration of the unique aspects for children, youth, and families

1. Children and youth undergo tremendous developmental change through the phases of early childhood, school-age, and older adolescence into young adulthood. This period of brain plasticity means that a child's development is impacted by their relationships with significant adults, especially within the family system, but also through experiences of their surrounding environment, which can range from healthy and growth-promoting to impairment-inducing.

2. Efforts to promote the healthy emotional and social development of children and their family members can have tremendous benefits for our communities in the long-term. These benefits include school readiness, academic success, choosing healthy behaviors, positive peer/family relationships, and positive involvement in their community.

3. Integrated care incorporates wellness, prevention/promotion, resilience-development, trauma-responsive care, and early intervention across child and youth developmental stages and across all settings where children live, learn, play.

4. In any health care reform initiative, there needs to be intentional consideration of the unique needs of children, youth and families through an equity lens that recognizes the intersectionality of marginalized sub-populations including racial or ethnic groups, LGBTQ+, or those identified by socioeconomic status and the additional impacts such marginalization can have on access to healthcare.

5. Integrated care must consider the child's needs in the context of their family, school, and community and coordinate with those respective system partners. Such care must actively seek out the voices of youth, family members, and caregivers and recognize that families may have different pathways into mental health care.

6. Vermont's pediatric health care system is strong and presents regular opportunities to check on family functioning, screen for and address social contributors to health, screen for social-emotional-behavioral needs, and offer brief intervention and resource linkage. Primary Care can be an important first resource for parents/caregivers who have questions or concerns about mental health. Due to health policies for Medicaid coverage, medical homes provide near universal access.

Fundamental Building Blocks of Integrated Care

To meet these principles of care, the workgroup drafted an initial logic model which needs to be refined with input from the broader system. Briefly, the logic model proposes the clinical resources, practice frameworks, screening tools, expertise, funding and workforce needed to achieve integrated pediatric care. It also details the steps needed to source and implement those inputs, the kinds of data and other measures that would be available as a result of these changes, and the short and long-term outcomes to be expected. The Pediatric Care Workgroup will continue to gather feedback and refine the model.

Two key areas of focus, however, were discussed in more detail.

1. Mental Health Workforce - The mental health needs of children, youth, families, and adults will likely never be fully met by the professional workforce, even with the efforts to strengthen that workforce. A new public health approach founded on wellness, community, and equity is needed to address these issues. Everyone – children/youth, families, community

members, providers, schools – has a role in supporting healthy development of children and families; some may need different resources and support to fulfill that role.

2. Measurement of progress - we need the ability to measure progress toward the goal of integrated care for the pediatric population. While there are measures for the AIMS model, those were primarily designed for the adult population. In the SAMHSA-funded CHILD grant partnership with the UVM Vermont Child Health Improvement Program evaluator, a child and youth adapted measurement tool was used which could be a useful tool for other settings to consider when seeking to periodically measure progress towards integrated care for children, youth and families.

RECOMMENDATIONS

RESOURCES

2) Incentivize with resources (financial and implementation assistance) the integration of mental health within primary care serving child, youth and family through pediatric-specific applications of the locally selected integrated care model(s) to ensure wellness, not just reaction to problems.

   a) Communicate to health care and organizations the funding mechanism(s) to provide integrated care (coding for Collaborative Care Model (CoCM), Blueprint for Health) to support providers' actions to integrate mental health with primary care;

   b) identify effective approaches for prevention, such as wellness activities/roles; and

   c) specify that a portion of health reform budgets be spent in primary care for child-specific upstream investment. Also,

   d) ensure that every child has a medical home that includes some mental health staffing and coordinates (bi-directionally) with the child's family and community. The coordination must be financially incentivized.

3) Create a recruitment campaign to increase the child, youth & family mental health workforce (including peer supports) in Vermont, leveraging federal resources as much as possible. Focus can include telehealth resource options and partnerships with bordering states, in addition to promoting more people to move to Vermont.

4) Evaluate existing pediatric and perinatal psychiatric consultation services which support providers/entities who have questions about caring for mental health concerns (e.g. Vermont Child Psychiatry Access Program (VTCPAP) and Perinatal Psychiatric Consultation Service) for effectiveness and impact in our healthcare system and, if demonstrated, identify resources to sustain the services.

5) Increase integration of healthcare into Act 264 Coordinated Services Planning structures to support coordinated care for children and youth with disabilities.

CHANGE MANAGEMENT PROCESS

6) Identify responsible entity to provide training and/or technical assistance for the health care system (including care and services across the lifespan) and providers on how to use a quality improvement approach within and among organizations when taking steps to integrate.

   a) Track the focus and the quality of change, and improvement actions which might be transferable across organizations

   b) Identify a Continuous Quality Improvement (CQI) entity to

i) conduct strengths-based system reviews of integration efforts

ii) extract lessons learned that can be shared to support other integration efforts

iii) seek the voice and input of people who are recipients of the integrated services

STRUCTURES, PATHWAYS AND TOOLS

7) Develop and implement routine feedback loops for child/youth/family and peer support specialists' perspectives on the pathways to mental health care to inform policy and services.

   a) Leverage existing structures as well as new approaches to ensure the input of those who experience health disparities or other barriers to care.

   b) Improve public messaging about the available pathways to care.

8) Form a cross-sector Pediatric Measurement Team** to:

   a) Solidify a standard core set of metrics, ideally through alignment of existing metrics, that build on strengths and protective factors, along with social contributors to health and other measures used by the Division of Maternal Child Health (VDH) of flourishing communities to drive public-health-focused investments in strong, active, and connected communities

   b) Clarify where accountability lies and the group or entities that would hold the metrics

   c) Create a state- and community-level set of indicators that help DMH and DA's optimize programming, workforce, and outreach in the service of (a) expanding access to child- and family-based care, and (b) the capacity of the extant system to respond to community needs WHILE MOVING UPSTREAM in terms of prevention

   d) Identify data stewards in state government and health reform to have governance of these data

   e) Keep track of data development needs in the continuum of socio-emotional measures and clinical measures (i.e. what data do we wish we had but don't have easy access to)

******** *DRAFT Pediatric measurement team representation:* pediatric healthcare including American Association of Pediatrics leaders, health reform representatives (i.e. Blueprint for Health, OneCare Vermont) and Medicaid partners at Agency of Human Services, Vermont Department of Health including Maternal and Child Health Division, Department of Mental Health

Goal: To design, monitor and continuously improve a slate of pediatric quality measures that reflect prevention and early intervention along with traditional health care quality measures with an overarching goal of optimizing child and family health

Examples of what we could do when starting with pediatric mental health

1) assemble or develop wellness measures drawing from: Strengthening Families Protective Factors, Help Me Grow, Health Outcomes of Positive Experiences, Flourishing metrics

2) measure and monitor social contributors to health, including family indicators that impact child development

3) monitor current and evolving state and national pediatric mental health care quality measures (across the pediatric age spectrum) and provide feedback/recommendations on the implementation and use of these measures to Vermont groups with relevant policy and regulatory oversight.

Integration of Funding & Alignment of Performance Measures

The Integration of Funding and Alignment of Performance Measures Workgroup has identified existing initiatives throughout Vermont that include performance measures and funding mechanisms for integration of mental health care into broader health care service delivery. As part of this work, Workgroup members have highlighted opportunities and challenges to the integration of funding and performance measures between physical and mental health. Workgroup discussions and review of services covered by health insurance payers in Vermont and the existing performance measures on health outcomes have provided a roadmap for actionable next steps to ensure that mental health care continues to be integrated with physical health care services in a bi-directional manner. Additional discussions have focused on examining funding in a broader context, in order to assess billing barriers faced by community providers and organizations, and on conducting an introductory exploration of prospective payment models to improve the financial sustainability of healthcare providers and organizations.

The Workgroup began with one-on-one structured interviews with members to gather stakeholder input and inform the Workgroup's activities. The following questions provided the framework for these discussions.

1. What successes have you experienced (or any successes of which you are aware) regarding the integration of mental health into the broader health care (physical health) system, specifically from your perspective and expertise?
2. What challenges/barriers have you experienced (or any challenges/barriers of which you are aware) regarding the integration of mental health into the broader healthcare (physical health) system, specifically from your perspective and expertise?
3. What opportunities do you think currently exist that would facilitate the increased integration of mental health and physical health care that are not currently being pursued?
4. What metrics should we (Funding & Alignment of Performance Measures Workgroup) track and monitor regarding the integration of funding and performance measures?

Results of these interviews, as well as ongoing Workgroup sessions during MHIC meetings, illuminated the following information on existing work that is occurring within Vermont related to the alignment of funding and performance measures:

- Vermont Care Partners and Designated Agencies
    - Four (4) Vermont DAs (Clara Martin Center; Health Care and Rehabilitation Services of Vermont; Northeast Kingdom Human Services; Rutland Mental Health Services) won CCBHC Planning, Development, and Implementation Grants by SAMHSA to help to transform local mental health care systems to provide comprehensive, coordinated mental health care.
        - See "Grants Dashboard | SAMHSA for award overviews
- Mountain Care Board (GMCB)
    - GMCB provides publicly available reports and analyses, as well as a performance dashboard, that provides quantitative and qualitative information on Vermont's health care system using the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database.
        - Public Reports and Analyses | Green Mountain Care Board (vermont.gov)
        - Profile – state.of.vermont | Tableau Public
- Department of Vermont Health Access (DVHA)

- DVHA's Quality Assurance and Performance Improvement Program measures health outcomes for Medicaid enrollee members, including experiences and satisfaction of care, quality of services provided, and cost efficiency.
    - DVHA tracks performance through standardized Healthcare Effectiveness Data and Information Set (HEDIS) measures via the Adult and Child Quality Measure Core Sets to standardize the measurement of healthcare quality across state Medicaid programs.
- Vermont Child and Adult Core Sets
    - Child Core Set of Health Care Quality Measures for Vermont Medicaid - 2021 (clearimpact.com)
    - Adult Core Set of Health Care Quality Measures for Vermont Medicaid - 2021 (clearimpact.com)
- OneCare Vermont
    - OneCare Vermont, the state's Accountable Care Organization, collaborates with health care providers and organizations annually to establish value-based care targets and provide financial incentives for those meeting or exceeding benchmarks.
    - Through this work, OneCare develops an annual quality work plan focusing on quality assurance activities, performance measurement, and performance improvement activities. As part of this oversight, OneCare provides publicly available data on shared interest quality measures focusing both on mental and physical health outcomes by the following payers:
        - Medicaid Next Generation: PowerPoint Presentation (onecarevt.org)
        - Medicare: PowerPoint Presentation (onecarevt.org)
        - Blue Cross Blue Shield of Vermont
            - Qualified Health Plan: PowerPoint Presentation (onecarevt.org)
            - Primary Population: PowerPoint Presentation (onecarevt.org)
        - MVP Qualified Health Plan: PowerPoint Presentation (onecarevt.org)
- Vermont Program for Quality in Health Care (VPQHC)
    - VPQHC facilitates reform efforts in health care throughout the state through application of quality improvement methodologies and stakeholder engagement to improve the health care experiences and outcomes for all Vermonters.
    - This past year, VPQHC led a working group to design a framework of meaningful metrics that provides relevant information and accurately reflects the hospital system's quality of care within the state's healthcare reform environment.
        - This work involved significant stakeholder engagement from state government, health care provider organizations, and health insurance payers that resulted in a measure set inclusive of both mental and physical health metrics.
            - VT_Hospital_Quality_Framework_Report_2022.pdf (squarespace.com)

While Vermont continues to be a national leader in health care reform initiatives, more work is needed to improve the alignment of funding for mental and physical health care and the performance measurement of health care delivery and health outcomes of Vermonters. One component of these efforts involves an explicit focus on health equity that ensures that all Vermonters, irrespective of race/ethnicity, gender, socioeconomic status, education level, or ability status, have access to and use of the highest quality of health care and that health care providers receive sustainable reimbursement rates, irrespective of payer. Workgroup members highlighted the work of Advance Vermont's Equity Initiative, which is guided by the vision of equity being "The recognition and repair of structural injustice in social, economic, and political systems." Given this information, this Workgroup proposes the

following recommendations:

- Conduct a formal needs assessment to assess: 1) the parity of covered services by Vermont's health insurance payers, 2) use of performance measures across health care providers and organizations, state government entities, and health insurance payers. This assessment would also include a focus on:
    - Financial, quality, policy, and legal issues,
    - Existing services covered by health insurance payer and any gaps in services due to lack of coverage or limited coverage, and
    - Use of medical billing codes that assist with receiving integrated care and provide a method for measuring the delivery of integrated care.
- Pilot selected integration models in different health care settings applying rigorous improvement science methodology using associated resources, in order to study the impact on health care delivery funding and any improvement on established performance measures. Some example models for a pilot that have been identified through the MHIC include:
    - University of Washington Advancing Integrated Mental Health Solutions in Integrated Care (AIMS) Center: AIMS Center | Advancing Integrated Mental Health Solutions in Integrated Care (uw.edu)
    - Agency for Healthcare Research and Quality Academy Integrating Behavioral & Primary Care: Integrating Behavioral Health & Primary Care| AHRQ Academy

These recommendations would provide an opportunity to better understand the barriers that Vermonters face when accessing integrated care, as well as the challenges Vermont health care providers experience in attempts to offer integrated care, through a data-driven, standardized approach to assess the impact of any associated efforts.

Integration of Workforce Development

The Workforce Development Workgroup identified opportunities for collaboration as well as a broad range of areas to explore further. Importantly, a co-facilitator of this workgroup (Kheya Ganguly, Director of Trauma Prevention and Resilience Development, DMH) is a member and new vice-chair of the Health Equity Advisory Commission (HEAC). The Workgroup's discussions, recommendations and on-going work are informed by the HEAC's mission and goals, and these recommendations include a section on training taken verbatim from the recent HEAC report[1].

The Workgroup began their discussions focused on staff for hospital emergency departments. The group agreed that in addition to needing more staff, certain trainings could help minimize crisis situations in emergency departments, and therefore reduce stress on staff as well as those seeking care. Discussion also included the potential for peers to provide support in emergency rooms.

Training that the group recommends for emergency department staff when the demand for care would allow time for it are the following.

- Six Core Strategies for reducing seclusion and restraint training
- Trauma-informed care
- Health equity
- Working with peers (certification process must be in place)

Shared or Leveraged Staffing

The staffing shortages that challenge all sectors of health care are expected to continue for the foreseeable future. Addressing these critical shortages is a primary focus for this workgroup. The following first steps were identified.

- **Examine** FQHC, DA and CCBHC opportunities for shared or leveraged staffing through contracting.
  - Are there differences in skill and license that are needed to serve mental health at a community mental health center versus an FQHC or other healthcare setting?
- Explore how care may be "best served" at a DA, CCBHC or an FQHC.
  - Is serving adults with Serious Mental Illness and children and youth with Serious Emotional Disturbance equal to "specialty care" in healthcare?
  - Develop workforce to best meet those needs.
  - Develop recommendations for training specialists
  - Develop recommendations for compensating for that specialty.

- Develop guiding principles for Workforce Development
  - identify current successful examples
    - Suicide Safe Pathways to Care mini grant project. Public/private partnership between Dept of Mental Health and the Center for Health and Learning offered small grant opportunities for participation in a six-month action-oriented effort. Leveraging existing Blueprint resources for coordination, 17 primary care practices signed up to partner with their local

[1] https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf

mental health agency to develop a protocol for how identification, triage and referral of suicidal individuals would be well managed in their regions. Primary Care engaged in specific training on how to talk with patients experiencing suicidality about access to lethal means and provided data on the type of screenings they provide to assist with identification. Goal to increase use and fidelity to evidence-based practices of screening, referral and follow up, build relationships between primary care and mental health, and develop a shared understanding of how someone in suicidal crisis can be best served leveraging integrated resources.

- Examples of areas to be explored
  - reimbursement rates and mechanisms to bill co-occurring treatment
  - Medicaid and non-Medicaid parity [see Funding & Alignment of Performance Measures Workgroup recommendation]
  - Shared staffing
  - Develop training plan to expand co-occurring workforce in Vermont
  - Update requirements for medical school curriculum, internships or rotations to include how to care for those experiencing a mental health challenge - *DMU Becomes First Medical School to Require Mental Health Course for Students | who13.com*
  - Telehealth and other opportunities to leverage qualified staff

Equity

The Workforce Development Workgroup agreed that building equity across all sectors of health care must be prioritized.

One important way to improve cultural competency in Vermont's healthcare system is to ensure representation from more cultures among Vermont's healthcare system workers. HEAC has identified several factors that can help or hinder such representation. The group has also identified opportunities to create new equitable services for marginalized populations or strengthen existing services.

These recommendations align with or repeat those of the HEAC.

- Recruitment
  - Update and expand definitions of professions
    - Specify which professions are "healthcare system workers." Does this term include, for example
      - Mental health clinicians
      - Peers
      - Recovery coaches
  - Dismantle barriers to entry
    - Academic, financial, and regulatory inequities make it harder for people from marginalized communities to enter healthcare professions[2].
    - Licensing
      - Exams for all licensed professions for must require more knowledge and understanding about health equity, inclusion, and accessibility

[2] Health Equity Advisory Commission, Report on Continuing Education, Nov. 1, 2022 https://legislature.vermont.gov/assets/Legislative-Reports/HEAC_Report_on_Continuing_Education_10-31-2022.pdf

        - Leverage Act 107, 2022 (An act relating to telehealth licensure and registration) and to provisional licensure for professions regulated by the Office of Professional Regulation) to create a Health Equity Telehealth Program specifically to provide access to a broader selection of providers who possess the cultural competency and humility required to provide the appropriate care to marginalized communities
        - Formally request a review by the Office of Professional Regulation of the relevant inter-state licensure requirements to ensure that out-of-state telehealth providers are held to the same standards of health equity training as Vermont-based providers
        - Ensure that peer support providers are trained in health equity
    - Pay for prospective workers' travel and moving expenses
    - Provide onboarding and educational materials in more languages
    - Consider specifically how professionals can serve in under-saturated practice areas, such as group support in mental health services and among rural populations
- Existing community support groups
    - Create grant opportunities overseen by the HEAC to provide services to marginalized populations
- Create a model of reimbursement or insurance coverage requirements for alternative therapies such as reiki, herbalism, Chinese medicine and other nonwestern approaches.

Health Equity Advisory Council (HEAC) Training recommendations

"The Commission has engaged in extensive discussions on training and education to drive systemic transformation. There is consensus that some existing training and education is actively harmful because they present misconceptions and inaccuracies that perpetuate stereotypes."

- To correct these systemic issues requires
    - continuous, ongoing training and education curricula for all State employees
    - all State contractors must receive training
    - training must be interconnected to avoid creation or strengthening of silos (pg.6 of HEAC Continual Training Report)

Ongoing Training and Education

- "Create standardized baseline awareness training on origins, impact and mitigation approaches to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism. (HEAC, in consultation with leaders from impacted communities and equity industry associations).
- Create a statewide mandate to ensure equity training and education is amongst the highest of priorities and essential for professional development. Communicate the urgency and priority of education against homophobia/transphobia, ableism, and systemic racism alongside existing trainings that are already heavily weighted, such as Equal Opportunity gender-related anti-bias trainings and sexual harassment prevention trainings.
- Ensure that all employees understand their role in furthering systemic change.

- Training and education should be role-based and created in conjunction with impacted community leaders and equity professional associations.
- Legislation is needed that requires equity training for billing staff, paramedics, receptionists, schedulers, social workers, peer supports and anyone else who plays a significant role in patient experiences or outcomes.
- Training should include the topics of LGBTQIA+ communities, understanding disability, cultural humility, systemic racism, bias, and other areas mentioned by [the HEAC] report.
- Create specific community-based trainings in collaboration with professional and community voices.
- The HEAC should vet and maintain an accessible menu of these trainings for interested parties to access.
- Create a defined protocol for how to address instances of harassment or discrimination in healthcare settings, especially racial discrimination. To practice anti-racism in meaningful ways, healthcare institutions and other impactful sectors must insist on living out a shared set of values and committing to upholding them.
- Implementing the cultural changes to dismantle systemic racism includes having a robust and effective discipline policy for perpetrators of discrimination and/or harassment, providing socio-emotional support for those who experience discrimination or harassment, and implementing or updating the staff and patient codes of conduct to reflect shared values.
- Ensure adequate resourcing to include time and finances for training the healthcare delivery workforce and expanded definitions of healthcare workers, including a robust community health workforce to meet people where they choose.
- Create a programmatic training co-operative that is available at no cost to ensure access for all which is managed by the HEAC
- Rather than mandating training, the legislature should consider the option of providing some benefits for engaging in this training such as a tax credit.
- Create culturally sensitive training on alternatives to medical model - i.e., Reiki, massage, acupuncture, shamans, naturopaths and others.: (pp. 15-16, HEAC Report)

- Look for opportunities to address health inequities in Corrections populations
    - Consider trainings for those who work with inmates after release to make sure they receive integrated services