0:0:0.0 --> 0:0:0.390
Hentcy, Kathleen (she/her)
Thanks.

0:0:4.540 --> 0:0:5.700
Hentcy, Kathleen (she/her)
Great. So Ena.

0:0:7.220 --> 0:0:10.300
Hentcy, Kathleen (she/her)
Can you give us that perspective about healthcare reform?

0:0:10.810 --> 0:0:11.770
Saroyan, John M
Yes, thanks.

0:0:12.440 --> 0:0:19.410
Saroyan, John M
Kathy, good morning, everyone. I hope everyone can hear me. I'm sitting a little bit away, alright? Great.

0:0:20.40 --> 0:0:20.620
Saroyan, John M
And.

0:0:21.290 --> 0:0:26.720
Saroyan, John M
Doctor Saroyan and I wanted to be in the same room together because we have so much to talk about, and we can.

0:0:28.260 --> 0:0:58.570
Saroyan, John M
Exchange ideas here together in the same place. Healthcare reform. I think it it's a it is a broad. It is a very broad and encompassing topic and it is not necessarily specific to one particular initiative or reform model. When I try to ground myself in healthcare reform, I think it's helpful to think about key examples of of healthcare reform work in in history.

0:0:58.650 --> 0:1:29.890
Saroyan, John M
And one of those that's in fairly recent history is the Affordable Care Act. And I think when a lot of people think about health care reform, they think about the Affordable Care Act and within that act, so many things were contained within it. Yeah, insurance, marketplace reform, prescription drug reform. At one time, there was in the Affordable Care Act effort to establish long term care insurance, public long term care insurance.

0:1:29.960 --> 0:1:35.420
Saroyan, John M
Program for people just this sweeping package of different ways.

0:1:35.500 --> 0:1:37.340
Saroyan, John M
And and different.

0:1:38.20 --> 0:2:8.850
Saroyan, John M
Uh proposals and initiatives to better support persons throughout the whole healthcare system and in different ways of interacting with the healthcare system. So whether it was expanding Medicaid coverage or providing subsidies for persons purchasing commercial insurance or establishing essential health benefits, a benchmark of concrete benefits that people who are purchasing insurance in the marketplace.

0:2:8.930 --> 0:2:22.940
Saroyan, John M
To be able to avail themselves up, that's all a part of certainly work that was launched with the Affordable Care Act work that we continue to engage in today in the healthcare reform space in Vermont.

0:2:23.640 --> 0:2:58.240
Saroyan, John M
And that is all health care reform. Some colleagues of mine always say what problem are you trying to solve in health care? Are you trying to get more people access to the system via coverage, making sure that people have coverage so that they can access the system like you're trying to ensure parity of coverage for mental health services and physical health care services? There's been a lot of work in that space in the state of Vermont prior to the Affordable Care Act. And then the Affordable Care Act really enshrining some of the work that Vermont.

0:2:58.320 --> 0:3:29.170
Saroyan, John M
Did for the nation, that's another part of healthcare reform. And then the Affordable Care Act also created the Center for Medicare and Medicaid Innovation, which was really grounded in working with states to develop models to pay differently for healthcare, reimburse differently for health care. And then through those changed reimbursement models delivering services differently.

0:3:29.410 --> 0:3:52.380
Saroyan, John M
We have a lot of experience in that space in Vermont, both now today and prior to the Affordable Care Act. Some of what the Affordable Care Act was supporting, such as patient centered medical homes, for example, through these change payment and delivery models, Vermont had a history and was working on that prior, I think.

0:3:53.510 --> 0:4:23.540
Saroyan, John M
The question we should ask ourselves when we're working in any realm of the health care reform space, whether it be looking at the essential health benefits or thinking about ways to reimburse differently for services, is whether or not those approaches are supporting whole person integrated care. And one of the examples recently or more recently that might be interesting to talk through is.

0:4:23.880 --> 0:4:29.550
Saroyan, John M
The recent change in what the essential health benefits and the benchmark plan.

0:4:30.240 --> 0:4:43.990
Saroyan, John M
For coverage in the state of Vermont, looks like when a small group or an individual or purchasing insurance in Vermont, what is the benchmark plan of coverage? And one of the things that.

0:4:44.360 --> 0:5:14.380
Saroyan, John M
Umm that we thought through along with the Department of Financial Regulation and the Green Mountain Care Board and the Department of Vermont Health Access and a lot of what my role encompasses is coordinating among these departments and agencies and the Green Mountain Care Board was what? What makes sense in terms of the benchmark plan for essential health benefits for people to receive and hearing aids was one of those items that was looked at closely.

0:5:14.480 --> 0:5:32.210
Saroyan, John M
Recommended and is now included in the benchmark plan, and I think that's a a really interesting example because hearing aids really do support whole person care and better health and well-being in all avenues of life where so.

0:5:33.250 --> 0:6:3.160
Saroyan, John M
Being able to hear means you may feel less isolated. Being able to hear may also mean that your balance is improved and you are less likely to fall or be at risk. So I think that's a that's a great example about how we can be looking through that lens to support whole person integrated care, no matter kind of the health care reform realm that we're working in.

0:6:3.580 --> 0:6:16.330
Saroyan, John M
And we can certainly talk more about payment and delivery for reform. And I'm interested to talk some about whether you have to do payment reform to do delivery system transformation or not.

0:6:16.820 --> 0:6:17.290
Saroyan, John M
Uh.

0:6:18.370 --> 0:6:26.710
Saroyan, John M
And and certainly the way that those those pieces also shape and can provide for more integrated whole person care.

0:6:28.380 --> 0:6:48.450
Hentcy, Kathleen (she/her)
Great. Good that that was very helpful. Thank you, Anna. So, yeah. So, Doctor Saroyan, let's, let's go to

you. If you could tell us a bit about the blueprint for health and how health care, how you imagine healthcare reform will affect care, you know, what kind of changes you're anticipating?

0:6:49.240 --> 0:6:56.610
Saroyan, John M
Sure, Kathy, I'm not sure people know who I am as well as they know who Anna is. Is it OK if I just say a few words about myself?

0:6:56.770 --> 0:6:59.270
Hentcy, Kathleen (she/her)
Please, please do. Yes, definitely.

0:6:58.410 --> 0:7:30.80
Saroyan, John M
His wife, while I've been on the pediatric subcommittee, I I don't know as if I've introduced myself to the group. Good morning, everyone. It's nice to see some of you and nice to just look at the list of distinguished participants in this in this, this group. And Kathy, thank you for the introduction and organizing us all so beautifully. Ian and I are here in Waterbury today. I feel a little bit like we should have a mug of coffee on on both sides of our our camera and being doing like.

0:7:30.160 --> 0:8:0.930
Saroyan, John M
Like a New York City kind of morning show or something like that. But anyways, I'm. I'm John saroyan. I live in Norwich, Vt. I moved to Vermont in 2013 to become the Hospice medical director in New Hampshire and Vermont for Bayada home health care and transition to this role. On January 3rd. And I'm thrilled to be taking my knowledge of of the many different communities of Vermont to a role that can really put that to work. Speaking of hearing aids.

0:8:1.560 --> 0:8:14.430
Saroyan, John M
My, my, my wife and my son both need hearing aids because there's a genetic component in some sensory neural hearing loss. So the the hearing aid benefit hits my home in a very.

0:8:15.690 --> 0:8:46.720
Saroyan, John M
A big way, but it it hits all of us because whether it's our colleagues or our families, hearing loss is, is, is so common amongst people that we can communicate better, even if they're we're not the ones receiving them and they're they're very, very expensive technologies. So just to bring it, bring it home to that, Kathy, I think that my answer to your question is sometimes a little unexpected because of the bootprints history.

0:8:46.820 --> 0:9:17.130
Saroyan, John M
And its leadership in the past and the legislature and the executive branch and also as the executive directors and their wonderful staff have been because blueprint for health has both been an instrument of healthcare reform and been an influencer of healthcare reform nationally. There are parts of the the

language in, in, in the Affordable Care Act that do mention patient centered medical homes. And I'm pretty sure though I can't reference it myself.

0:9:17.220 --> 0:9:47.440
Saroyan, John M
Off the top of my head, do mention community health teams, so I think it's easy to get for me and others. It's easy to get confused about who's affecting whom, and it's exciting for me to work down the hallway from Ena and others who are still trying to influence the direction of the national leaderships approach to healthcare. Based on our experience in the blueprint. So I'll get to your question now, that was just all.

0:9:47.530 --> 0:10:20.870
Saroyan, John M
I'll background Kathy the blueprint for health has several components programmatically. One is the patient centered medical home. This is written in the statute in Vermont that to be a medical home in Vermont and to be up what's called a blueprint practice. A practice needs to meet the standards of becoming a patient centered medical homes. That's a model of care that focuses on patients at the forefront and building better relationships between patients and their clinical teams.

0:10:21.740 --> 0:10:51.400
Saroyan, John M
Research generally about patient centered medical homes, but also multiple studies about blueprint for health in Vermont have looked at its improvement in quality patient experience also, staff satisfaction while reducing healthcare costs. So just the patient centered medical home alone is a way to look at healthcare delivery and effect costs. I think that Vermont is the envy of many places, especially for example when we meet.

0:10:51.480 --> 0:10:57.780
Saroyan, John M
With New York States Office of Medicaid because they have the patient centered medical home aspect of it.

0:10:58.470 --> 0:11:28.620
Saroyan, John M
They don't have the community health team aspect of it, and the Community health team is in concert with the patient centered medical home as a multidisciplinary team that takes that, that focus on the person, the family, the individual and provides, particularly in the beginning, but even even now, the types of services that are not reimbursed at all perhaps are not reimbursed well, perhaps come at a high copay.

0:11:28.760 --> 0:11:46.630
Saroyan, John M
And and provide a more and and and possibly a complete equal distribution of those services. For example, care coordination, nutritional services, access to self management, perhaps a community health worker, many other ways that are different.

0:11:47.360 --> 0:11:55.40
Saroyan, John M
A leaders around the state utilize dollars for community health teams and community health teams in concert with the patient centered medical homes.

0:11:56.320 --> 0:12:25.950
Saroyan, John M
In in the pilot studies that were part of the blueprint, in addition to evaluations in the late 2000, teens continued to look at those being able to bend the cost curve and also keep people out of inpatient stays and and Ed utilization. So those are two of the programs that really were the core of the blueprint since then and because of the Affordable Care Act, the hub and SPOKES program, also a very much a national leader in Vermont, the envy of many other states.

0:12:26.130 --> 0:12:56.300
Saroyan, John M
For the treatment of opioid use disorder. And while I think we have the the position and the responsibility now in 2022 to look at how that program can maybe modelled in other ways around mental health and a non opioid substance use disorders the the fact that that Vermont has a hub and spokes program that was built really over three years because of an opportunity for not just matching funding but what's called 9010 funding from the federal government for quite a while.

0:12:57.240 --> 0:13:12.270
Saroyan, John M
Vermont took advantage of that and and we need to do more. But again, those those types of systems are are what put us at the forefront, still at the same time that all of you know we we have.

0:13:13.530 --> 0:13:35.300
Saroyan, John M
Problems both in mental physical health and substance use disorder that are that are off the charts right now that need more investment that that need more invention and innovation to to address better. Kathy all paused there. I haven't mentioned all the programs of Blueprint. For example Women's Health initiative. But I think that's a strong overview at least to get us started this morning.

0:13:38.530 --> 0:13:41.690
Hentcy, Kathleen (she/her)
Great. Thank you, Doctor Stroyan, this the very helpful.

0:13:43.130 --> 0:13:52.120
Hentcy, Kathleen (she/her)
I thought maybe next week could move to Doctor Levine. We've been more focused on sort of practice level questions.

0:13:53.840 --> 0:13:59.840
Hentcy, Kathleen (she/her)
But VDH of course works on the population level, and so I'm wondering, Doctor Levine, if you can.

0:14:1.520 --> 0:14:12.310
Hentcy, Kathleen (she/her)

Kind of reflect on where you think healthcare reform is going to affect the public health world and if, if there are examples that come to mind.

0:14:13.470 --> 0:14:14.0
Hentcy, Kathleen (she/her)
Is that?

0:14:14.860 --> 0:14:17.600
Hentcy, Kathleen (she/her)
Is that too broad a question or does that work?

0:14:20.500 --> 0:14:20.750
Hentcy, Kathleen (she/her)
OK.

0:14:18.870 --> 0:14:21.840
Levine, Mark
On that works just fine. Good morning everyone.

0:14:23.350 --> 0:14:24.280
Levine, Mark
I'm going to.

0:14:25.380 --> 0:14:27.670
Levine, Mark
Begin what I have to say with.

0:14:29.150 --> 0:14:30.850
Levine, Mark
The so-called triple aim.

0:14:32.120 --> 0:14:34.820
Levine, Mark
Because that's kind of integrates everything together.

0:14:35.910 --> 0:14:50.760
Levine, Mark
Many in this audience will actually recognize the term. Others will be like what's he talking about? So the triple aim is a pretty simple concept. It basically looks at healthcare reform in a very global manner and says.

0:14:51.380 --> 0:15:1.240
Levine, Mark
Umm, part of what's going on now that needs to be corrected. It's been going on forever. Is we pay way too much for the healthcare that we get.

0:15:1.940 --> 0:15:12.430
Levine, Mark

Uh, so costs the other part as either was using in the terms delivery system. Reform is we don't always get the biggest bang for our buck.

0:15:13.590 --> 0:15:18.320
Levine, Mark
So that really looks at issues of quality of care performance management.

0:15:19.500 --> 0:15:25.310
Levine, Mark
I'll use the word customer in quotes, customer satisfaction or patient satisfaction.

0:15:26.500 --> 0:15:39.260
Levine, Mark
And then the third part of the triple lane is actually the word health. So is what we're doing actually creating a healthier individual and a healthier population.

0:15:40.460 --> 0:15:49.850
Levine, Mark
Now we are in very troubled times post pandemic, so it's probably appropriate to say that many have extended the triple AM to the quadruple aim.

0:15:50.570 --> 0:15:57.850
Levine, Mark
And the 4th part of the quadruple lane has to do with the health of the workforce.

0:15:58.640 --> 0:16:12.150
Levine, Mark
And where everybody's at, so not only we try to help people, as we always do in healthcare to attain the highest level of health, but our workforce has to be a consideration as well, so.

0:16:13.100 --> 0:16:16.290
Levine, Mark
When I look at healthcare reform.

0:16:17.110 --> 0:16:47.290
Levine, Mark
It's very obvious, I think, to most people at this meeting that cost is always the thing that gets focused on the most and and remains a constant focus. But that delivery system reform has indeed been a significant component, and programs like the blueprint are the tip of the iceberg here. But so much has happened with the way health care is delivered and the focus on quality.

0:16:47.700 --> 0:16:49.950
Levine, Mark
And patient safety specifically.

0:16:52.330 --> 0:17:5.270
Levine, Mark
The forgotten stepchild generally is that health, part of the AAA, and thank goodness the Affordable Care Act did occur because it did begin to elevate that to some degree.

0:17:5.960 --> 0:17:7.890
Levine, Mark
Although when you're trying to really.

0:17:9.30 --> 0:17:15.510
Levine, Mark
Overhaul a healthcare system. Those other two factors really drive the ship, if you will.

0:17:16.670 --> 0:17:21.150
Levine, Mark
And the issue of access always has been a significant driver.

0:17:21.940 --> 0:17:29.680
Levine, Mark
So as a public health leader in the state and as the department that really focuses on the whole population.

0:17:30.120 --> 0:17:32.370
Levine, Mark
Uh, we are very much in.

0:17:33.650 --> 0:17:37.380
Levine, Mark
Significantly looking at access all the time.

0:17:38.300 --> 0:17:48.440
Levine, Mark
And when you think about the kinds of principles that we want to have for our healthcare access and affordability are certainly two of the highest along with of course equity.

0:17:49.440 --> 0:17:50.90
Levine, Mark
So.

0:17:50.820 --> 0:18:22.750
Levine, Mark
The Affordable Care Act was hit with a significant blow, with the Supreme Court number of years ago. As you'll recall, on the issue of Medicaid expansion to everyone, and we do have still a core number of states in the country that have not benefited from the kind of Medicaid expansion that we in the Northeast are very familiar with. And that's important because generally these are the states that need it the most.

0:18:23.530 --> 0:18:26.670
Levine, Mark
And they needed the most, mostly for issues of HealthEquity.

0:18:27.770 --> 0:18:32.370
Levine, Mark
And to be frank, quite often racial equity so.

0:18:33.430 --> 0:18:46.550
Levine, Mark
That is a serious problem in our country right now because not every state is in the same kind of reform stance because they have that opportunity to opt out of full expansion.

0:18:47.660 --> 0:18:48.680
Levine, Mark
Having said that.

0:18:50.710 --> 0:18:53.580
Levine, Mark
One, when you're looking at population health.

0:18:54.450 --> 0:19:2.710
Levine, Mark
Concepts like what is the big what is the return on investment going to be if something gets invested in?

0:19:4.640 --> 0:19:6.320
Levine, Mark
Is there more value?

0:19:7.530 --> 0:19:12.360
Levine, Mark
As we transition from so-called fee for service systems to value based care.

0:19:13.600 --> 0:19:21.880
Levine, Mark
And what the populations getting. So if you just look at the problem of, let's say tobacco use tobacco and vaping.

0:19:22.490 --> 0:19:23.950
Levine, Mark
Uh, clearly.

0:19:24.490 --> 0:19:43.740
Levine, Mark
Uh, just minor investment like in state quit lines and access to the quit lines and allowing the population who can afford it the least the Medicaid population to have free access to smoking cessation counseling and aids.

0:19:45.540 --> 0:20:16.80
Levine, Mark
That can increase the sustainability of someone smoking related efforts, sensation related efforts substantially for a fairly small investment to be quite honest, and we all know that tobacco leads to such significant rates of disease in our population that costs gazillions of dollars. So just thinking with that kind of a mindset not only enhances the care that an individual will get.

0:20:17.600 --> 0:20:19.500
Levine, Mark
Just because this happened to smoke.

0:20:20.580 --> 0:20:50.590
Levine, Mark
But it will also do something much larger at the population level and then impact those other aspects of the triple aim triangle because you've reformed the delivery system to some extent with this action and your costs overall in the future are going to go down significantly when you consider that 80% of most of our healthcare costs go to chronic disease and think of the chronic disease as that tobacco use is leading towards.

0:20:51.650 --> 0:21:22.980
Levine, Mark
I also wanted to pivot off of what Anna was saying about those essential health benefits, because those are so important and within those health benefits, of course, are the opportunity to get screening tests at no cost and to have significant conditions screened 4. So this is the part of healthcare reform that really focuses on prevention, which is we're all health departments are focused all the time. Laser focused 100% of the time.

0:21:23.770 --> 0:21:27.30
Levine, Mark
The other place where we are focused and.

0:21:27.990 --> 0:21:48.190
Levine, Mark
That drives our state health improvement plan, which is a five year plan. We keep reiterating over over years and years to really get the state focused on what counts those. The two components now are called the upstream components. One is HealthEquity and the other is addressing the social determinants of health.

0:21:49.580 --> 0:21:56.850
Levine, Mark
And through the development of the Innovation Center that Ana was referring to, CMMI.

0:21:58.50 --> 0:22:11.980
Levine, Mark
We're making some small steps in that direction as a as a country, and of course states like Vermont are always interested in leading and trying to get there faster. But these are very heavy lifts and Needless to say.

0:22:13.180 --> 0:22:17.600
Levine, Mark
Especially when you think about the impact of housing and food security.

0:22:18.760 --> 0:22:33.790
Levine, Mark

And parity across education depend no matter what population would you live in. Those are very heavy lifts for any state or country to achieve, but that's how you achieve better health care so.

0:22:34.910 --> 0:22:42.380
Levine, Mark
As we make progress in that arena, obviously our work is a health department will be easier, but at the same time.

0:22:43.500 --> 0:22:56.870
Levine, Mark
We will find that health care reform has driven the kinds of upstream improvements in our systems that need to happen to enable people to be healthier in general.

0:22:57.730 --> 0:23:10.820
Levine, Mark
I've purposely purposefully avoided specific focus on mental health and substance use disorder in these comments, I wanted to keep them fairly general, not just so you'll know.

0:23:12.360 --> 0:23:18.670
Levine, Mark
There are five priority areas in our state health improvement plan. Three of them include.

0:23:19.390 --> 0:23:22.350
Levine, Mark
Uh. Prevention of chronic diseases.

0:23:23.240 --> 0:23:53.150
Levine, Mark
Improvements in oral health and child development, but the other two are the two that we're addressing in this Council every time we meet, which our mental health and substance use disorder, so they are very part and parcel in core to the entire mission of healthcare reform. And when we start thinking about what are these essential health benefits that everyone should have and what has the blueprint done already to provide some element of.

0:23:53.240 --> 0:24:3.720
Levine, Mark
Access to those kinds of benefits and mental health and substance use disorder we've made a lot of progress in our state and the work that we're doing in this Council can only get us further.

0:24:4.450 --> 0:24:15.610
Levine, Mark
So I I'll stop there, Kathy. So we can really keep our focus going as we have with our guests. But I think thanks, I appreciate your allowing me to provide that context.

0:24:16.280 --> 0:24:19.120
Hentcy, Kathleen (she/her)
Yeah. Great. Thank you. Doctor Levine was very helpful.

0:24:20.320 --> 0:24:24.800
Hentcy, Kathleen (she/her)
And then I wanted to shift to Allison.

0:24:25.600 --> 0:24:39.990
Hentcy, Kathleen (she/her)
We we've talked about certified community behavioral health clinics in within this Council and there have been, there's we have one CBHC they're called and by.

0:24:42.80 --> 0:25:3.350
Hentcy, Kathleen (she/her)
In short terms, and there's news about other grants, so it seemed like we should talk about the certified Community Behavioral Health Clinic model, how healthcare reform might affect that. And maybe you could give us sort of the context of the grants and and what's happening in Vermont right now.

0:25:4.860 --> 0:25:12.270
Krompf, Alison (she/her)
Sure. One of my favorite things about CBHC's is trying to watch people say the term CBHC.

0:25:13.590 --> 0:25:20.980
Krompf, Alison (she/her)
It's tricky. One. We do have Clara Martin, Center, who has been on this journey.

0:25:21.140 --> 0:25:32.740
Krompf, Alison (she/her)
Umm. And they started 1st and so then we have an additional planning grants that were awarded. So if you're not aware, we've got.

0:25:34.200 --> 0:25:38.670
Krompf, Alison (she/her)
HCRS that's healthcare rehabilitation services of southern Vermont.

0:25:39.910 --> 0:25:45.830
Krompf, Alison (she/her)
We've got the Northeast Kingdom Human Services, who received a planning grant and Rutland regional.

0:25:46.670 --> 0:25:55.810
Krompf, Alison (she/her)
Also received a planning grant and then Claire Martin Center. Their grant is to continue with their planning. So it's a little bit different than the others.

0:25:57.270 --> 0:26:5.410
Krompf, Alison (she/her)
And so for people wondering what this means, and I think in the context of what Doctor Saroyan and Ena and Doctor Levine have been talking about.

0:26:6.370 --> 0:26:11.510
Krompf, Alison (she/her)
We wouldn't have CBHC opportunity if there wasn't such a thing as healthcare reform.

0:26:12.310 --> 0:26:17.270
Krompf, Alison (she/her)
The whole thing is looking at how do we do different service delivery models and payment models.

0:26:18.930 --> 0:26:23.750
Krompf, Alison (she/her)
I think what makes this conversation interesting from DMH's lens is.

0:26:24.870 --> 0:26:54.180
Krompf, Alison (she/her)
We've actually started payment reform already and so some of this stuff, when we think about, you know why moving this direction of CBHC I think to enus question of you know, do we have to do certain payment reforms to do certain service delivery models. And so one thing the state is really interested in is making sure can we do it a lot of the things people want to do without going through certain prescribed.

0:26:55.780 --> 0:27:1.480
Krompf, Alison (she/her)
Additional regulation and and and compliance and what does that actually get us?

0:27:2.550 --> 0:27:19.890
Krompf, Alison (she/her)
So right now what that actually gets us is more money, which is really attractive in the world that we're living in right now. And so we've seen our community mental health agencies being interested in this for a few reasons. One, it fits the mission right, which is to start moving towards more integrated care.

0:27:21.50 --> 0:27:23.380
Krompf, Alison (she/her)
CBHC are really focused on.

0:27:24.240 --> 0:27:31.570
Krompf, Alison (she/her)
Having the opportunity for somebody who walks in that door to get more medical screening, more physical health consultation.

0:27:32.460 --> 0:27:41.930
Krompf, Alison (she/her)
To get more substance, use screening and more substance use treatment. That's intentionally broadening what is looked at for that human being.

0:27:43.100 --> 0:27:58.190
Krompf, Alison (she/her)
And then it talks about maybe some lines of focus like for example, they really want people looking at veterans status and and military connections so that they can make sure we're connecting folks to those services. So it's kind of naming that.

0:27:59.130 --> 0:28:5.400
Krompf, Alison (she/her)
It's naming peers as if major part of the puzzle, which has been a focus of this Council.

0:28:6.730 --> 0:28:10.60
Krompf, Alison (she/her)
And then it's talking about mobile crisis response, which has been.

0:28:10.660 --> 0:28:18.490
Krompf, Alison (she/her)
Umm, something that we have heard from families year over year over year that what they want is to receive the services where they're at.

0:28:19.270 --> 0:28:23.700
Krompf, Alison (she/her)
In this program requires that there's 24/7 mobile crisis response.

0:28:24.610 --> 0:28:33.80
Krompf, Alison (she/her)
And it requires that that response has some the ability to have a pure component and that they can do integrated crisis response.

0:28:33.720 --> 0:28:38.90
Krompf, Alison (she/her)
Integrated in that definition is substance use and mental health.

0:28:39.90 --> 0:28:50.620
Krompf, Alison (she/her)
So those are some of the things that are really sort of, I would call beefing up and and kind of making tangible. Here's the standard of what we're trying to do.

0:28:51.560 --> 0:29:0.520
Krompf, Alison (she/her)
And for the community mental health agencies, those aren't fitting with their values and what they've seen as needs for for their populations.

0:29:2.160 --> 0:29:8.390
Krompf, Alison (she/her)
I think in this is where you know this is be something that warrants further discussion.

0:29:9.150 --> 0:29:15.840
Krompf, Alison (she/her)
Some of these things we could do without shifting to a new way of payment, and some of these things.

0:29:16.670 --> 0:29:33.710
Krompf, Alison (she/her)
Were seeing as. Here's some opportunity that helps us pay for the uninsured and underinsured and helps, you know, make it easier for flow and somebody coming into the system and for the agencies to remain stable as they serve people with variable levels of insurance and need.

0:29:34.990 --> 0:29:38.300
Krompf, Alison (she/her)
And so I think it'll be interesting to see how this bears out.

0:29:39.80 --> 0:29:46.670
Krompf, Alison (she/her)
What makes CBC's different in the way they're paid is there's, we'll call it, cost related reimbursement.

0:29:47.630 --> 0:29:49.460
Krompf, Alison (she/her)
And I say that because.

0:29:50.170 --> 0:29:58.380
Krompf, Alison (she/her)
I do want to make sure we're all clear that there's there's no such thing as, just like a blank check. If we say, OK, here's what it costs that we magically just deliver that number.

0:29:59.20 --> 0:30:14.460
Krompf, Alison (she/her)
And unfortunately there there's there's a certain cap on the amount of dollars that there are, but this opportunity has come with some additional sort of here's some additional funding you can get and here's why. And so we're all very interested to see what that can deliver.

0:30:15.220 --> 0:30:21.210
Krompf, Alison (she/her)
Umm. And how we how we figure that out and then write size it to the services that are occurring.

0:30:21.980 --> 0:30:42.180
Krompf, Alison (she/her)
And so that's an exciting thing. There's a lot of homework to do, and so I attend along with my DMH partners and a lot of the community mental health folks. There's a policy Academy we've been going once a month. Every time we go, you learn more about, OK, what are the actual nuts and bolts that come along with this?

0:30:44.170 --> 0:30:45.200
Krompf, Alison (she/her)
And I think.

0:30:46.10 --> 0:30:52.660
Krompf, Alison (she/her)
Kathy, did you want me to talk about unintended consequences that were concerned about or is that a follow up for later?

0:30:54.640 --> 0:31:8.360
Hentcy, Kathleen (she/her)
Well, yeah, maybe you could give us some points about that. And then we'll then I was gonna go back to Enna for a few more specifics about healthcare reform itself. So yeah, that that could be good to hear that now.

0:31:10.190 --> 0:31:22.860
Krompf, Alison (she/her)
Sure. I think when we think about this and we hear about healthcare reform and other areas, we had a great discussion about this at our Workforce Development Subcommittee on Friday, which is part of this Council.

0:31:23.820 --> 0:31:32.200
Krompf, Alison (she/her)
And we talked about how for those of us in the mental health world, it makes you nervous to hear about mental health services expanding and healthcare.

0:31:32.980 --> 0:31:58.770
Krompf, Alison (she/her)
Because what you're what you're worried about is well, OK, great. Now here I am trying to serve over here. Someone else is gonna try to do something similar at it organization that's only open during business hours and potentially my some folks think works with a less acute clientele. How are we going to manage this? And isn't this going to suck up my mental health workforce?

0:31:59.440 --> 0:32:19.650
Krompf, Alison (she/her)
And so we're talking about how to just think forward about that, because I think it's easy to say. So then everybody go back to their corners and let's not mess with anything. And I think we've said the goal of this Council is to provide more integrated healthcare, which means more mental health in healthcare spaces.

0:32:20.900 --> 0:32:25.500
Krompf, Alison (she/her)
And so how can we be thoughtful about the realities of staffing?

0:32:26.770 --> 0:32:35.170
Krompf, Alison (she/her)
How can we really talk about shared staffing, about how we can maximize and do contracting with each other so that people understand?

0:32:35.900 --> 0:32:36.200
Krompf, Alison (she/her)
What?

0:32:36.900 --> 0:33:0.540
Krompf, Alison (she/her)
You know, hubs and spokes can provide, but maybe have somebody in their clinic who is contracted with the community Mental Health Agency who can help you, that bridge, how are we going to do some shared staffing with psychiatry and nursing and things that are limited resources? What can that do for making sure that everybody understands what each organization offers and we then can refer appropriately.

0:33:1.380 --> 0:33:13.80
Krompf, Alison (she/her)

And so that's one thing that I think we need to keep talking about as opposed to just kind of being afraid of because I think it's it's going to be easy to to have this, that stop us in our tracks.

0:33:14.80 --> 0:33:15.640
Krompf, Alison (she/her)
And the only other thing I'll name is.

0:33:16.270 --> 0:33:23.850
Krompf, Alison (she/her)
For the our the folks have been in the room who represent different peer communities.

0:33:25.100 --> 0:33:33.610
Krompf, Alison (she/her)
I've heard them saying that, you know, let's keep an eye on how medical model this is. There's still a lot of medical model pieces to the CBHC.

0:33:34.370 --> 0:33:39.70
Krompf, Alison (she/her)
And a lot of health care reform in terms of great, we're not doing fee for service.

0:33:39.890 --> 0:33:58.950
Krompf, Alison (she/her)
But we are saying, well, let's face it, on quality and performance and how much of that quality and performance is really steeped in a medical model that doesn't feel to the person like it's reflecting back what they care about. And so we're interested in seeing what's flexible about that.

0:33:59.200 --> 0:34:12.10
Hentcy, Kathleen (she/her)
Yeah, Allison, I, I and not to put you on the spot, but I'm wondering, we and I do this, we use the term medical model. Can you give me an idea of what you mean by that like?

0:34:12.860 --> 0:34:21.500
Hentcy, Kathleen (she/her)
Why would it matter? What? What do we mean in your and it? And it matters like your perspective. What does the medical model encompass?

0:34:22.870 --> 0:34:25.910
Krompf, Alison (she/her)
Yeah, that's a great question. Thanks for stopping me in that one.

0:34:26.590 --> 0:34:27.830
Krompf, Alison (she/her)
When I think of what?

0:34:28.660 --> 0:34:31.930
Krompf, Alison (she/her)
But I my opinion on that it's.

0:34:32.260 --> 0:34:32.970
Krompf, Alison (she/her)
Uh.

0:34:34.330 --> 0:35:6.100
Krompf, Alison (she/her)
More Western than eastern medicine. It's more diagnostic beast and it's more. I'll give you an example of something that really drew people's attention when they saw BMI as a major factor. If somebody coming in the for one of the first things is we're going to do is we're going to look at your body mass index and we're going to decide if that's OK or not. OK and we're going to set a goal for that. And for that person, they've said maybe that's not my goal. And where do I get a say in any of that?

0:35:6.750 --> 0:35:14.720
Krompf, Alison (she/her)
And so that idea of a prescribed sort of hierarchical, the experts have decided what's important.

0:35:15.460 --> 0:35:24.750
Krompf, Alison (she/her)
Umm. And we're fitting you into something that's really prescribed and then it's decided by someone else whether things are going well or not going well.

0:35:25.630 --> 0:35:28.350
Hentcy, Kathleen (she/her)
That's great. Thank you. That's really helpful.

0:35:29.310 --> 0:35:48.360
Hentcy, Kathleen (she/her)
Umm, OK, thank you. I I I found that whole helpful. I hope others did as well and that just really that overview of CBHC and and the factors within our payment reform efforts that the department had embarked on in night in 2019.

0:35:50.740 --> 0:36:18.180
Hentcy, Kathleen (she/her)
And where we might be, where things might be headed with that. So, so we've done, you know, we've heard a bit about an overview about healthcare reform. We've heard a bit about how the blueprint functions and and intersects with healthcare reform and then the population health interests and the certified Community behavioral health clinics. So I'm wondering now, could we kind of step back a bit again and go back to Enna?

0:36:18.860 --> 0:36:36.760
Hentcy, Kathleen (she/her)
And if if you could, when we last talked, when we were talking about this meeting and how this would go, you mentioned 2025 as the significant point in healthcare reform. Can you tell us a bit about that? What what significant about 2025?

0:36:38.770 --> 0:37:8.760
Saroyan, John M
I can talk about 2025, but I I want to start by responding to some of the things that both Allison and

Doctor Levine said and get to 2025 through through those responses. Because I think what Doctor Levine said about the triple aim as an impetus for payment and delivery system reform is is incredibly important and is helpful for us to ground our thinking.

0:37:9.130 --> 0:37:32.20
Saroyan, John M
Why are we talking about paying differently for health care services? And what does that mean? The predominant reimbursement system for healthcare services in the United States and in other countries too? But speaking just about the United States now has been fee for service reimbursement and?

0:37:33.430 --> 0:37:44.240
Saroyan, John M
The the other piece about that that I has been the predominant component of fee for service reimbursement is if you think about it as one end of a continuum.

0:37:45.210 --> 0:37:46.800
Saroyan, John M
The the.

0:37:47.590 --> 0:38:4.820
Saroyan, John M
The first end of the continuum, and again the predominant way that people are paid is fee for service reimbursement with no tie to quality or value. That fee for service reimbursement occurs regardless of outcomes, regardless of the of the.

0:38:4.900 --> 0:38:21.470
Saroyan, John M
That value of that service and that is if you think of it again as a continuum, that's one end of the continuum. And then if if you consider that you have a goal to move away from fee for service because of the incentives of that payment.

0:38:22.280 --> 0:38:52.360
Saroyan, John M
That payment for every procedure in service, regardless of what the outcome is or the quality of those procedures and services, which is again the way we primarily pay in the United States and have historically, and then consider if you start tying payment to quality and outcomes, what that looks like in the blueprint is actually an example of that. The blueprint moves the away from feet.

0:38:52.450 --> 0:39:24.610
Saroyan, John M
Your service, because the model includes enhanced payments for high performing primary care patients that are medical homes and the blueprint also includes more flexible payments and investments in the Community health teams and that those are supporting integration of services and care and starting to move away from what Allison mentioned about the the silos of care happening in silos. So you.

0:39:24.720 --> 0:39:39.650
Saroyan, John M

Have a model that's becoming more flexible, moving away from fee for service and for example, really promoting integrated care with the spoke example being an excellent one of the primary care.

0:39:40.270 --> 0:40:9.720
Saroyan, John M
Uh, primary care. Having a multidisciplinary care team that is supporting physicians in that practice and the practitioners in that setting in providing medication assisted treatment for persons with opioid use disorders and that. So the the blueprint model is an alternative to fee for service. So it's moving away from fee for service with no tie to quality and outcomes.

0:40:10.80 --> 0:40:10.740
Saroyan, John M
To.

0:40:10.970 --> 0:40:23.200
Saroyan, John M
And the alternative payment model that does have a tie for quality and outcomes and includes payments that flow differently than just a reimbursement for every service and procedure that is performed.

0:40:24.10 --> 0:40:38.950
Saroyan, John M
Then in our work in payment reform in the state of Vermont, and we have also had a goal to move even further from fee for service more towards a global payment.

0:40:39.710 --> 0:41:10.120
Saroyan, John M
So instead of fee for service with an enhancement like the blueprint program is really a a truly global payment for health care services for a population of people, and that global payment is also then linked to quality outcomes and value for the population. And the idea behind that global payment is it provides even more flexibility because it's being provided up front.

0:41:10.830 --> 0:41:15.190
Saroyan, John M
Giving the health care system and and providers working within the global payment.

0:41:16.20 --> 0:41:29.360
Saroyan, John M
A budget to manage with in and a model that's more flexible than just being paid for that for any particular service, a model that can help to provide for.

0:41:30.160 --> 0:42:0.280
Saroyan, John M
A budget so that preventive activities can occur, coordination between and among providers can be supported providers. Time working with each other to gain experience and expertise from a multidisciplinary in a multidisciplinary approach, supporting multidisciplinary teams and teams that include unlicensed providers, for example, like potentially community health workers.

0:42:0.550 --> 0:42:5.880
Saroyan, John M
As a part of that overall care team working in this more flexible arrangement.

0:42:6.880 --> 0:42:39.450
Saroyan, John M
That's the that's the that's getting all the way to the other end of the continuum. And I think my question that I was posing about, do you need to do payment change necessarily meaning not pay fee for service in order to deliver care differently? I was posing that question because I think that there's probably a mix, a mix of reimbursement models that need to be implemented in a complementary nature and likely the opportunity to tie these different.

0:42:39.560 --> 0:42:50.670
Saroyan, John M
Reimbursement models together, but not every reimbursement model necessarily is uniform for all providers and provider types in the system, for example.

0:42:51.540 --> 0:43:5.130
Hentcy, Kathleen (she/her)
Anna, can I interrupt you for a second? You use the term I I just love that. That was really, really helpful to hear. And you use the term multidisciplinary a couple times.

0:43:5.800 --> 0:43:12.260
Hentcy, Kathleen (she/her)
Is that another word for some level of integration? When you say multidisciplinary?

0:43:13.520 --> 0:43:29.40
Saroyan, John M
Yes, I I think so. That's it. That's how I think of it. Absolutely. And team members who are all coming together and collaborating and providing care for a person across a number of different.

0:43:30.510 --> 0:43:38.960
Saroyan, John M
Needs and including different expertise and service types, but all working together to deliver whole person integrated care.

0:43:39.900 --> 0:43:40.290
Saroyan, John M
Yeah.

0:43:45.210 --> 0:43:46.540
Hentcy, Kathleen (she/her)
Great. Thank you and.

0:43:47.820 --> 0:43:50.430
Hentcy, Kathleen (she/her)
Can you take us to 2025 also?

0:43:50.950 --> 0:44:7.620
Saroyan, John M
Uh, yes. So well in in terms, again, we've been we've been working to ensure that or to we've been working towards a goal of aligning these fee for service alternative payment models across payer types.

0:44:8.250 --> 0:44:10.340
Saroyan, John M
And that's very important.

0:44:11.80 --> 0:44:11.970
Saroyan, John M
Because.

0:44:12.790 --> 0:44:30.980
Saroyan, John M
If only Medicaid is paying differently and expecting particular outcomes, and Medicare and commercial payers are are expecting or paying a different way and expecting different outcomes than the incentives are not necessarily aligned and.

0:44:31.340 --> 0:44:59.410
Saroyan, John M
Uh, the reimbursement model is not necessarily supporting that alternative delivery or that team based care, for example. And the blueprint is a great example of again of of a model that is aligned across payer types to an extent, commercial pairs participate, not all commercial insurance participates but commercial insurance does participate.

0:45:0.230 --> 0:45:25.290
Saroyan, John M
Medicare participates and Medicaid participates and Medicare participates via are all payer model agreement that we have currently where we're moving towards and have implemented in the Medicaid payment model in the all payer model a more a more prospective population based payment.

0:45:26.210 --> 0:45:27.150
Saroyan, John M
Provided for.

0:45:27.490 --> 0:45:35.300
Saroyan, John M
And provided to hospitals through Medicaid that are participating in the Accountable care organization.

0:45:36.0 --> 0:45:37.810
Saroyan, John M
And we have.

0:45:39.240 --> 0:45:39.960
Saroyan, John M
We have.

0:45:40.920 --> 0:45:59.180
Saroyan, John M
The reason why 2025 is is interesting is because we have proposed to extend our all payer model agreement and are working on that extension with our federal partners. Our current agreement which the again provides for Medicare participation in paying.

0:45:59.840 --> 0:46:27.190
Saroyan, John M
An accountable care organization in Vermont differently than fee for service. That's one care Vermont commercial payers are paying one care differently than fee for service. And again, Medicaid is probably the most advanced in doing this and providing for these population based payments. We've we've we're looking to extend that arrangement while we then work with our partners in Innovation Center to consider.

0:46:27.930 --> 0:46:57.660
Saroyan, John M
And how that model may advance beyond 2025, Vermont proposed A1 year extension and we wanted to work towards a more longer term extension from that point forward. Our partners in the Innovation Center are really focused on how they broaden models to more states. And they said that they were looking for some more time to realize those goals and objectives and they have offered that Vermont could extend.

0:46:57.750 --> 0:47:0.880
Saroyan, John M
Our agreement for two years instead of 1.

0:47:1.820 --> 0:47:31.870
Saroyan, John M
So that they can do the work that they want to do, to invite more states into participating in these alternative payment models. So that's that's why we're looking forward to beyond a potential extension of our agreement, how we continue to advance in moving away from fee for service in 25 and beyond with Medicare potentially as a partner, but certainly in our Medicaid program as we've been doing and in commercial.

0:47:32.170 --> 0:48:4.540
Saroyan, John M
Spaces as well, and I think there is an objective to continue pushing away from fee for service more towards global payment arrangements and there's a lot of things to think about in that aspect, attribution how people are attributed to these models have been sort of central to paying differently. Who are you paying differently on behalf of and how do you identify these people? And I think that that's a place where we have a lot of room for innovation and improvement.

0:48:4.630 --> 0:48:8.430
Saroyan, John M
For example, and also to be thinking differently about.

0:48:9.90 --> 0:48:14.800
Saroyan, John M
HealthEquity and addressing health related social needs, because when we're talking about.

0:48:15.830 --> 0:48:45.640
Saroyan, John M
Persons coming into these models and being attributed based on how they experience the healthcare system, I think we can think a lot differently about the population on the whole and how the population on the whole may or may not access healthcare services in a way that identifies an individual for attribution. So how do we think more globally to encompass those persons in our system that may not that may not engage in it.

0:48:45.780 --> 0:48:46.470
Saroyan, John M
In a more.

0:48:47.560 --> 0:48:51.550
Saroyan, John M
Certainly in the ways that have been identified to date for attribution.

0:48:52.480 --> 0:48:52.870
Saroyan, John M
So.

0:48:55.410 --> 0:49:20.690
Hentcy, Kathleen (she/her)
Well, I'm wondering. I I don't wanna go too much into the weeds, but you've mentioned the accountable care organization. We know there's the VM's Health Network. We know there's the blueprint for health, and I'm just thinking and then there are private practices still out there. There are the hospital systems where that are, you know, that are part of the Accountable care organization for the most part. But you know, for the.

0:49:21.340 --> 0:49:22.790
Hentcy, Kathleen (she/her)
Person out there.

0:49:24.360 --> 0:49:31.390
Hentcy, Kathleen (she/her)
Who's not steeped in healthcare reform? I'm wondering, is there a thumbnail you could give us of just?

0:49:32.290 --> 0:49:53.560
Hentcy, Kathleen (she/her)
You know, here's the accountable care organization and what that means, you know, just really briefly, just so people are like, wait a minute, you know, we talked about the blueprint for health and and you've just mentioned the accountable care organization. You see what I'm just to try to maybe if we could just get the threads distinct.

0:49:54.750 --> 0:49:56.500
Hentcy, Kathleen (she/her)
I think that might be helpful.

0:49:57.90 --> 0:50:26.530
Saroyan, John M
Yeah, absolutely. The the blueprint is rooted in the primary care setting, although it certainly pushes the envelope both beyond primary care and supports primary care extending into multidisciplinary teams. And that is a foundation in Vermont's healthcare system and has been working. And as Doctor Saroyan mentioned, successful.

0:50:27.40 --> 0:50:46.450
Saroyan, John M
With a valuated results and independent review by our partners and the federal government determining that that it is a strong program that's been happening since 2000, I mean really launching around 2006 and going statewide by 2010 or 11.

0:50:47.90 --> 0:50:52.950
Saroyan, John M
Uh, and we, we consider that absolutely important foundation for.

0:50:54.80 --> 0:51:24.390
Saroyan, John M
Payment and delivery reform that is more broad and encompassing of a much larger range of provider types. So you mentioned one care accountable care organization that is a network of provider types that is much larger than primary care provider types. And so providers across the state are participating in one care, Vermont as a network in that network includes hospitals. It includes primary care providers, it includes home health providers.

0:51:24.750 --> 0:51:30.580
Saroyan, John M
Mental health and substance use disorder treatment providers all participating.

0:51:31.360 --> 0:51:38.70
Saroyan, John M
In that model and working again as a network to.

0:51:39.10 --> 0:51:43.780
Saroyan, John M
Deliver within an alternative payment model savings.

0:51:43.970 --> 0:52:15.400
Saroyan, John M
And savings relative to a benchmark for healthcare spending. So if you think of it as one care has a benchmark, all of the providers working within it are working together to try to do better than that benchmark. And when they do, then there's savings are available to be flexibly invested across that system of care that's engaging and working together to improve back to Doctor Levine's point to improve health.

0:52:16.230 --> 0:52:20.120
Saroyan, John M
To improve outcomes for Vermonters and to lower cost.

0:52:25.820 --> 0:52:44.660
Hentcy, Kathleen (she/her)
Thank you. That was helpful. And I I wanted to go back to Doctor Saroyan, but before that I just wanted, does anybody Allison or Doctor Levine or Doctor Saroyan, do you have follow-ups for eina? Are there points that you feel like you would like to talk about a little bit more?

0:52:45.840 --> 0:52:50.170
Hentcy, Kathleen (she/her)
And it's and if not, that's fine. I just want to give you the opportunity.

0:52:56.420 --> 0:52:56.700
Hentcy, Kathleen (she/her)
Yeah.

0:52:57.660 --> 0:52:59.260
Hentcy, Kathleen (she/her)
It's so big, yeah.

0:52:52.310 --> 0:53:0.220
Krompf, Alison (she/her)
I would say even I am digesting when Elena is saying because it's such a big world. So I I'm just gonna validate that if I'm not alone.

0:53:0.890 --> 0:53:3.260
Hentcy, Kathleen (she/her)
Yeah, yeah. OK, great.

0:53:4.280 --> 0:53:18.290
Hentcy, Kathleen (she/her)
OK. So thank you Rena. I that was helpful again. So Doctor Story and I wanted to go back to the blueprint. We, you gave us a really good grounding in that when we started.

0:53:48.250 --> 0:53:48.800
Saroyan, John M
Current.

0:53:19.380 --> 0:53:50.270
Hentcy, Kathleen (she/her)
With all of this discussion, I think it's really helpful, as Allison just named. This is just so big and it's so complex with for the blueprint for health. Can you give us and again, this is all uncertain. We don't know exactly what's going to happen, but how do you imagine healthcare reform, what what are the differences for for the practices out there, can you can you give us some ideas about that for health care within the realm of healthcare reform?

0:53:51.10 --> 0:54:18.100
Saroyan, John M
Sure. I think that, Umm, I I know that practices or stretched, they're seeing more people with more complicated conditions sometimes at one time or more unexpectedly than they ever have in their career. They're seeing people with what I call multiple different issues and problems and multiple different areas of their health, their family, their Wellness, their security and their jobs and their homes.

0:54:19.280 --> 0:54:53.60
Saroyan, John M
And they're very overwhelmed. They're very exhausted. And there's a spectrum of what's the term burnouts use. But there's a spectrum of experience over what the the pandemic put on top of what they were already feeling and the term healthcare reform can sometimes be met with a feeling of dread or fear or apprehension that the promise that was maybe suggested this number of years ago or something that they they read or heard or were told or entered into an agreement.

0:54:53.180 --> 0:54:57.180
Saroyan, John M
With hasn't delivered, so sometimes there's even a feeling of.

0:55:1.460 --> 0:55:2.770
Saroyan, John M
Anger. Resentment.

0:55:5.150 --> 0:55:6.720
Saroyan, John M
And I think that the.

0:55:7.940 --> 0:55:37.90
Saroyan, John M
The what? What I value about the the blueprint. Kathy, is that there? There are tangibles to it that I can easily identify with multiple reassurances as I've traveled the state and visited all of our administrative entities, all but one to say that aspects of the blueprint which are rooted in healthcare reform like becoming a patient centered medical home still have value. They helped us recruit.

0:55:37.610 --> 0:55:53.800
Saroyan, John M
Neck, you know, person acts. They helped us interview person Y, our community health teams in some in some areas of our state know that if a person's been in the emergency department, that doesn't have a.

0:55:55.300 --> 0:56:24.940
Saroyan, John M
A patient, a primary care physician that there's a member of the Community health team that follows up with them right away. There's members of our spokes team and the opioid hub and spokes treatment that know if someone's gotten seen in an emergency department, they can get them moving with treatment of their opioid use disorder within 24 to 48 hours very quickly. So they're aspects that come from legislation that come both at the state and the federal level that do create.

0:56:25.70 --> 0:56:29.210
Saroyan, John M
I'm opportunities for recruitment, for better quality, for more timely care.

0:56:30.630 --> 0:56:56.430
Saroyan, John M
And those are those are tangibles, the the the complexities of of attribution, the the financial modeling, those are those are quite daunting and they take considerable study and evaluation and time to figure out which parts were which didn't work so well. But I hope I've named a few of the tangibles that blueprint continues to develop.

0:56:58.0 --> 0:57:22.300
Saroyan, John M
Excuse me? Not developed deliver for, for clinicians and and thereby families and individuals too. Most of what I hear is I talk to people is they want more, they want more Community health team members. They want expanded capacity. They want to receive more for being and maintaining patient centered medical home recognition.

0:57:23.440 --> 0:57:48.830
Saroyan, John M
Those, those are the some which is is is 111 in a leadership position isn't always able to deliver those things. On the other hand in in terms of a topic that for many is rather hard to digest and maybe even distasteful, it is positive I guess to hear that there are some aspects of it that people want more of.

0:57:49.630 --> 0:58:5.610
Saroyan, John M
And and Community health teams, the hub and Spokes program, our patient centered medical home there. Those are things that people I hear over and over again. These parts are working. We wish we could do even more of it. There could be two of me. There could be three of me to meet the needs of the Vermonters.

0:58:6.810 --> 0:58:11.120
Saroyan, John M
In in need of all sorts of of of of, of different things and.

0:58:12.280 --> 0:58:31.970
Saroyan, John M
I think that the Community health team members that I've met have longevity. They have investment and it's also fun to meet a lot of clinicians who've known about the blueprint since it's pilot phases and are still enthusiastic about it. Those things are unusual in the topic of healthcare reform.

0:58:33.90 --> 0:58:37.520
Saroyan, John M
Even for people who are dedicated and optimistic and leaning into it, it's it's.

0:58:39.0 --> 0:58:47.30
Saroyan, John M

In my experience, and people can certainly disagree, it's unusual to have like those things are working well. We like those things. We want more of them.

0:58:48.140 --> 0:58:50.520
Hentcy, Kathleen (she/her)
No, that's great. That's that's great.

0:58:51.750 --> 0:59:8.710
Hentcy, Kathleen (she/her)
And I was going to go back to Edna about how healthcare reform, where you see it really directly affecting integration. But before we do that, I'm just realizing, I wonder there's this term attribution.

0:59:10.120 --> 0:59:18.80
Hentcy, Kathleen (she/her)
I wonder if just if you could quickly tell us what what is that about? What do you mean by attribution and and why is it important?

0:59:21.100 --> 0:59:21.390
Saroyan, John M
I.

0:59:22.320 --> 0:59:43.830
Saroyan, John M
It the the term attribution is not necessarily important for this discussion that I I, but I think we have been working in these models that change the way Healthcare is paid for and they change it in based on attribution meaning.

0:59:45.610 --> 1:0:12.510
Saroyan, John M
Your payment for your or your reimbursement changes if a particular patient that has a particular payer is attributed to you and then you have the responsibility for managing within that payment for example, or managing the risk for example and delivering.

1:0:13.390 --> 1:0:16.60
Saroyan, John M
Better outcomes, better performance.

1:0:17.220 --> 1:0:33.910
Saroyan, John M
On behalf of this population of payment of people, excuse me, that are attributed. So the term accountable care, the accountability. You're accountable for those persons that are attributed.

1:0:35.560 --> 1:0:43.250
Saroyan, John M
If if a person is not attributed, then you're not financially accountable or accountable for outcomes.

1:0:44.370 --> 1:0:52.380
Saroyan, John M
But I want to be very careful about that because, you know, not every Vermonter is attributed to.

1:0:53.130 --> 1:1:23.920
Saroyan, John M
The Accountable Care organization, for instance, and the providers who are participating in the Accountable Care organization just because we're not every Vermonter is attributed doesn't mean that they aren't changing how they're delivering care for everyone that they see. And that's also been true with the blueprint, with the blueprint. There is also an attribution based payment system for the performance enhanced payments that primary care practices get. But as I referenced earlier.

1:1:24.60 --> 1:1:37.340
Saroyan, John M
Not all payers are are participating in that and so that means not all Vermonters are attributed for the purposes of payment because maybe they have a plan like with.

1:1:39.50 --> 1:1:45.500
Saroyan, John M
A National Health plan like I don't know, Blue Cross Blue Shield of Minnesota or you know.

1:1:46.760 --> 1:1:55.200
Saroyan, John M
And they're seeing a Vermont provider, but Blue Cross Blue Shield of Minnesota doesn't make payments for Vermont's blueprint for health program.

1:1:57.350 --> 1:2:17.380
Saroyan, John M
But I think what we're trying to consider is whether that model, which is very technical and very convoluted, is necessarily the best model for thinking and moving more reimbursement on the whole away from fee for service reimbursement. So that that's that's why I made that.

1:2:18.80 --> 1:2:18.930
Saroyan, John M
That comment.

1:2:19.600 --> 1:2:35.70
Hentcy, Kathleen (she/her)
And then like for me, an individual on the ground going to get care. Do I know or see anything about this attribution? Like to a personal on a personal level, does that mean anything to me?

1:2:36.250 --> 1:2:53.100
Saroyan, John M
You may receive a piece of mail that indicates that you are attributed to the Accountable care organization, for example, and that you would have the option not to have your data shared.

1:2:53.780 --> 1:2:54.380
Saroyan, John M
And.

1:2:55.20 --> 1:3:6.500
Saroyan, John M

That is something that you would be aware of if you receive that piece of mail. When it comes to how the teams are transforming and delivering care differently.

1:3:7.260 --> 1:3:8.90
Saroyan, John M
You may.

1:3:9.40 --> 1:3:18.800
Saroyan, John M
Observed some of that and you may not observe those the way that those things are changing. You know from your perspective you may.

1:3:19.500 --> 1:3:28.700
Saroyan, John M
Always have had connections to a multidisciplinary team and you continue to do so, and I think it's.

1:3:29.520 --> 1:3:29.850
Saroyan, John M
I.

1:3:30.940 --> 1:3:35.550
Saroyan, John M
It may not be something that you can readily observe.

1:3:36.310 --> 1:3:42.750
Hentcy, Kathleen (she/her)
Right. So essentially, it's really an administrative tool to group.

1:3:43.850 --> 1:3:53.480
Hentcy, Kathleen (she/her)
Numbers of Vermonters with different provider with some different networks, so that you can be trying to.

1:3:54.500 --> 1:3:58.720
Hentcy, Kathleen (she/her)
Influence how care is provided is that is that correct?

1:3:59.730 --> 1:4:30.720
Saroyan, John M
I think we say payment and delivery system reform and we save and we talk about it together because the payment is really meant to facilitate a change in the workflow for the delivery system and that's why they are coupled together. So it and I think that it is true that the delivery system may be very bound by some rigid rules and requirements that come or that are generated from fee for service.

1:4:41.250 --> 1:4:41.860
Hentcy, Kathleen (she/her)
Great.

1:5:0.100 --> 1:5:0.340
Hentcy, Kathleen (she/her)
Yeah.

1:4:31.270 --> 1:5:0.950
Saroyan, John M
System and without that being more flexible, it may be very different, difficult to adjust workflows and to adjust how you spend your time for example, and whether or not as a practitioner you are able to spend your time, perhaps coordinating with other practitioners and that isn't then a loss of revenue for example.

1:5:8.140 --> 1:5:9.90
Hentcy, Kathleen (she/her)
Great. Yeah.

1:5:14.130 --> 1:5:14.620
Hentcy, Kathleen (she/her)
OK.

1:5:1.200 --> 1:5:22.590
Saroyan, John M
For your organization or your independent practice, for example, so I don't think that it's. I don't think it's only administrative in function. I think it really is that coupling of the payment change and the delivery system transformation. I think we can support and there's.

1:5:23.410 --> 1:5:53.980
Saroyan, John M
There's a lot of work that supports delivery transformation. That's not necessarily payment change as well, like mentioned workforce at the outset of this meeting. And I think workforce development strategies very much can support delivery system transformation by introducing more workers into the pipeline, bringing more workers into training with multidisciplinary teams so that they are.

1:6:1.490 --> 1:6:1.870
Hentcy, Kathleen (she/her)
Yeah.

1:5:54.800 --> 1:6:11.250
Saroyan, John M
Uh, that they are accustomed to working across what have historically been silos in the system of care, and they really they really, you know, approach care with a very different, with a perhaps a very different.

1:6:13.130 --> 1:6:41.300
Saroyan, John M
Uh set set of tools to promote better care. I say that though wanting to be cognizant of how collaborative providers in our state are and how much providers and practitioners know one another work in the same communities, have patients in common and spend a huge amount of time working together as a community to.

1:6:41.970 --> 1:7:12.380
Saroyan, John M
Deliver good care and outcomes for Vermonters, and I think with all of the payment and delivery reform talk and we know that we always want to be at the leading edge and improving, but we shouldn't forget that our health outcomes in our state are very good that we lead among States and having good health outcomes that we have an older population and a population that's living in more in significantly more rural settings and being older and being in a rural.

1:7:12.700 --> 1:7:16.0
Saroyan, John M
State are usually associated with.

1:7:16.640 --> 1:7:42.870
Saroyan, John M
Poor health outcomes in the state of Vermont. We have both of those things in spades. Rural reality and older population. And yet we are still it ranking in the top of states in the healthiest in the nation. So I don't want to because we have ambition to continue to improve our system and we know that there's work to be done and we.

1:7:43.580 --> 1:7:51.730
Saroyan, John M
Want to and we wanted to accomplish that. I don't want it. Come away with the idea that we are not doing very good things.

1:7:53.20 --> 1:7:55.610
Saroyan, John M
Or the population already today that the.

1:7:58.80 --> 1:7:59.810
Hentcy, Kathleen (she/her)
Yeah. OK. Thank you.

1:8:1.430 --> 1:8:9.500
Hentcy, Kathleen (she/her)
So then if if I haven't worn you right out, INA, I wanna go back to the question about.

1:8:10.850 --> 1:8:28.600
Hentcy, Kathleen (she/her)
Health care reform, specifically around the issue of integration of tear, and if there are any examples that you could give us about, you know, individuals seeking care, how might it change the world for them and equity and parity issues?

1:8:29.630 --> 1:8:32.650
Hentcy, Kathleen (she/her)
Where? Where is this in that realm?

1:8:33.690 --> 1:8:40.620
Saroyan, John M

Yeah. And we'll do, we'll do this one in coffee talk style too, because we're here together in the in the room.

1:8:41.330 --> 1:9:9.720
Saroyan, John M
And I I mentioned this continuum of of payment change and I do think that that's an opportunity within that continuum to use payment to incentivize providers to work together in an integrated fashion and and to do so in a way that also might alleviate potentially some workforce pressures. So if imagine if a group of.

1:9:10.370 --> 1:9:30.500
Saroyan, John M
Providers are equally and providers in what we would consider at the traditional medical care setting and providers in a mental health care setting are equally accountable for a set of of quality metrics or outcomes for patients.

1:9:31.380 --> 1:9:37.410
Saroyan, John M
And any any of those providers lead on accomplishing that?

1:9:38.420 --> 1:9:55.350
Saroyan, John M
Process or delivering that service and that happens. Then the group of providers as a unit may be eligible for a a shared interest payment, a payment incentive that.

1:9:56.340 --> 1:10:8.680
Saroyan, John M
Yeah, is paid to the whole group of providers, but they don't all need to do the the task. The task needs to happen once and the providers are accountable to coordinate to make sure the task happens.

1:10:10.700 --> 1:10:29.650
Saroyan, John M
Happens at all, so that's that's an example of a payment change that could facilitate a more integrated model of care delivery. And then I think we also have some there in the blueprint. Again, building on the spoke model, there's also.

1:10:30.150 --> 1:10:47.560
Saroyan, John M
And potential other ways to promote more integrated care and service delivery that may be responsive to some of what providers in the field are saying again are the are the key issues that are.

1:10:48.420 --> 1:10:50.170
Saroyan, John M
Are more difficult to navigate.

1:10:50.420 --> 1:10:54.590
Saroyan, John M
And especially in in our current in our current state.

1:11:0.90 --> 1:11:5.40
Hentcy, Kathleen (she/her)
And Doctor Saroyan, did you have something you wanted to add there or?

1:11:6.280 --> 1:11:7.830
Saroyan, John M
Like an example, Kathy.

1:11:8.10 --> 1:11:13.760
Hentcy, Kathleen (she/her)
Yeah, I didn't. Since Anna was talking about the coffee morning coffee model.

1:11:13.150 --> 1:11:13.850
Saroyan, John M
Sure.

1:11:15.230 --> 1:11:15.780
Saroyan, John M
Sure.

1:11:18.470 --> 1:11:31.50
Saroyan, John M
I I'll just give a little background and then I I know we're we we went right through our break and we're into the the teams working time too. So I'll I'll try not to be too long winded is that is that true or am I wrong?

1:11:40.780 --> 1:11:42.90
Saroyan, John M
OK, OK.

1:11:42.440 --> 1:11:43.90
Hentcy, Kathleen (she/her)
I'm sorry.

1:11:44.280 --> 1:11:51.70
Hentcy, Kathleen (she/her)
And we can do this. We'll see how this and we can break earlier if if that happens. But yeah.

1:11:49.660 --> 1:11:53.300
Saroyan, John M
No, it's no. I'm happy to answer the question. Sure my.

1:11:52.320 --> 1:11:53.310
Hentcy, Kathleen (she/her)
OK. Thank you.

1:11:54.540 --> 1:11:58.990
Saroyan, John M
Thinking around the the whole person and the integrated care.

1:12:0.570 --> 1:12:4.480
Saroyan, John M
Language really comes from my my own experience.

1:12:6.770 --> 1:12:15.460
Saroyan, John M
As a quote UN quote patient person, someone being treated in healthcare settings, it comes from my interactions with.

1:12:17.560 --> 1:12:20.210
Saroyan, John M
Thousands of families, maybe more.

1:12:22.240 --> 1:12:50.370
Saroyan, John M
The some of whom are are very much wanting to get connected with a provider who may be labeled under the rubric of mental health and many, many others who the width or the sent of of anything labeled under the rubric of mental health they they've stopped listening to me. So the ability to help individuals whatever their needs are.

1:12:50.970 --> 1:13:1.440
Saroyan, John M
With a teammate who is, quote UN quote down the hall or available immediately through some other connection.

1:13:2.580 --> 1:13:25.990
Saroyan, John M
Is a very powerful relationship trust building mechanism to maximize a family or an individual's chances of of saying just a few more things about what's on their mind or why they think their house is unsafe, or why they feel threatened by someone in their their close circle.

1:13:27.290 --> 1:13:35.180
Saroyan, John M
Without without that team based care the the ability to.

1:13:36.40 --> 1:13:47.910
Saroyan, John M
Go down those threads that protects weren't listed in the chief complaint when the person called or sent a message as to why they're going to come in can be close to impossible without disrupting an entire.

1:13:48.650 --> 1:14:12.820
Saroyan, John M
Afternoon, morning, day. And not not to say that the disruptions not worthwhile, it's very worthwhile, but there's other people waiting and to have some degree of expertise on one's team to keep the conversation going, to do a little bit more of an assessment to see what what the immediacy is for me.

1:14:13.560 --> 1:14:20.210
Saroyan, John M
Whether it be labeled in the mental, the physical, or some other domain, maybe it's spiritual or existential.

1:14:21.430 --> 1:14:51.500
Saroyan, John M
That that is integrated care, that is whole person care. It's it's it's very difficult to convince payers that that's worthwhile. It's very difficult to year over year over year over year keep investing and proving that that's return on investment particularly to a clinician who believes in it was trained in it and maybe it was called something else when I was in medical school I can remember the term it was used but it's kind of the same thing as what it was labeled when I was in medical school whole person.

1:14:52.20 --> 1:15:22.790
Saroyan, John M
Yeah. I mean, the older labels don't matter, so that's that's where I see blueprint for health in conjunction with Edna's leadership as as Director of Healthcare Reform, giving us here in this small state, a chance at really being who we want to be being who we imagined we would become when we decided we wanted to be providers and healthcare. So that's that's how I see them being linked together both from the more granular.

1:15:22.910 --> 1:15:26.390
Saroyan, John M
To the more elaborate payment models.

1:15:28.250 --> 1:15:39.910
Hentcy, Kathleen (she/her)
Excuse me. That's really interesting point, Dr Saroyan. And it it makes me think back to Allison's comment about the medical model concerns.

1:15:41.500 --> 1:15:52.650
Hentcy, Kathleen (she/her)
And I wonder, maybe from your perspective, Doctor Saroyan, can you? You just did. You touched very much upon it, but I'm wondering really thinking about.

1:15:53.300 --> 1:15:57.230
Hentcy, Kathleen (she/her)
That term medical model that that we all use.

1:15:59.70 --> 1:16:9.440
Hentcy, Kathleen (she/her)
It can you reflect on that in terms of this integration and and what you just named with the Community health teams and and with healthcare reform.

1:16:11.300 --> 1:16:11.970
Hentcy, Kathleen (she/her)
How?

1:16:12.980 --> 1:16:14.880
Hentcy, Kathleen (she/her)
How you see health care reform?

1:16:16.0 --> 1:16:21.790
Hentcy, Kathleen (she/her)
Infecting, infecting that. That was quite the slip affecting.

1:16:24.300 --> 1:16:31.930
Hentcy, Kathleen (she/her)
The the this issue around medical model and mental health care. Do you? What do you think about that?

1:16:31.40 --> 1:17:2.890
Saroyan, John M
Sure, sure, I'll. I'll do my best. I I was trained as a pediatrician. My first mentor when I was in high school in the 1980s probably would have really shrieked if I tried it to divide up one of the children or families that we were taking care of with critical illness into different components. He he was a leader nationally and internationally in teams based care and and many of the principles that came out of pediatric oncology led to palliative care, led to some of this language, even with consultants.

1:17:2.990 --> 1:17:17.20
Saroyan, John M
We we talk with now around whole person care. So for me as an individual, even back into my medical school training, I was probably on the outside of the thinking that people are.

1:17:18.490 --> 1:17:34.90
Saroyan, John M
In the in the question you're asking, perhaps you're you're reflecting the concerns of people saying that I'm going to be medicalized, I'm going to be a chief complaint, diagnosed, labeled prescription out the door. Goodbye. So I think that that.

1:17:52.670 --> 1:17:52.890
Hentcy, Kathleen (she/her)
Yep.

1:17:34.990 --> 1:18:5.820
Saroyan, John M
That's not the way I've ever wanted to practice medicine. It's not the way I've ever wanted to train people. Of course, there are many episodes in one's life as a trainee and a clinician where that model saves lives over and over and over again in emergencies, in situations that are life threatening, where where that that model has to be employed to to do one's duty to the patient's. There's many other aspects of life living.

1:18:5.940 --> 1:18:10.150
Saroyan, John M
And wholeness and happiness and joy in one's life where.

1:18:11.40 --> 1:18:12.690
Saroyan, John M
Where that model can.

1:18:13.270 --> 1:18:33.840
Saroyan, John M
I'm alienate people or not be based in in, in building trust. It can make people feel pathologized or like they're broken. And I think that as a clinician and and now as a clinician who's in a leadership position, I want both to be available so that the patient and the family can.

1:18:34.230 --> 1:19:4.910
Saroyan, John M
And participate in the determination of of of, of, of, of how they want to be treated. But it's very difficult and complex to to to give an answer that somehow going to shape every single clinicians or practices ability to to do that whilst they are working in a system and they were trained in a way that while it allows for electives and other pursuits, they have to meet the standard of care of their licensure. There are natural paths.

1:19:5.0 --> 1:19:6.10
Saroyan, John M
You are or.

1:19:29.400 --> 1:19:30.770
Hentcy, Kathleen (she/her)
No, it's, you know.

1:19:6.710 --> 1:19:37.470
Saroyan, John M
I'm providers who participate in the blueprint. There's a natural path on our executive committee. I I certainly pride myself in learning more and and learning as much as I can to not just talk about this model, but find ways to deliver and support it as a, as an executive director, I hope I haven't talked around the issue too much. Kathy, it's a big question about which I feel very strongly, so I I'm happy to clarify anything I said or say more.

1:19:38.500 --> 1:19:44.710
Hentcy, Kathleen (she/her)
No, thank you. And you know, by the same token, I don't mean to be to put someone on the spot.

1:19:45.130 --> 1:19:51.840
Hentcy, Kathleen (she/her)
I to me this is again another example of there's not a hard and fast.

1:19:52.720 --> 1:20:25.130
Hentcy, Kathleen (she/her)
Three word answer. These are as you just named. Doctor Sharon is very complex and there are times when what we call the medical model is exactly appropriate. And so I I think naming it naming these concerns and talking about them, it's really it's really a central task of this Council to keep bringing out these points and getting them so that we're talking about them defining our terms.

1:20:25.930 --> 1:20:56.140
Hentcy, Kathleen (she/her)
So that we can be as clear as possible in the midst of all this uncertainty and change. So I again, I I thought that was helpful. I wanted to. Emma, can we talk about the issue of parity of and by that I'm talking about reimbursement for mental health services and medical health services, the parity issue of payment there and and issues of equity where you see healthcare reform.

1:20:56.560 --> 1:20:58.740
Hentcy, Kathleen (she/her)
Addressing these two huge.

1:20:59.450 --> 1:21:0.900
Hentcy, Kathleen (she/her)
Ohh topics.

1:21:16.180 --> 1:21:16.890
Arduengo, Sebastian
I'm still here.

1:21:3.860 --> 1:21:18.700
Saroyan, John M
Well, I saw my I saw my colleague Sebastian on the meeting a moment. At some point. He may or may not still be here. I can't quite see it at all of the participants, but I, you know, I think the the department. Ohh great.

1:21:20.340 --> 1:21:35.730
Saroyan, John M
So I don't want to speak. I don't wanna speak on behalf of of Sebastian, but I do know that the Department of Financial Regulation and its consumer protection role relative to commercial insurance coverage is doing a lot of work.

1:21:36.320 --> 1:21:45.70
Saroyan, John M
And that that certainly promotes parity consistent with what is required in terms of commercial.

1:21:57.20 --> 1:21:57.690
Arduengo, Sebastian
Yeah.

1:21:45.780 --> 1:22:13.560
Saroyan, John M
Coverage for mental health and substance use disorder services specifically, so I don't know if Sebastian wants to talk a little bit about that, but I think that that's really like my work is to coordinate those efforts. And you know, we we have, we have expertise in, in the DFR and the Green Mountain Care Board and the Agency of Human Services. And I want to lift up those expertise and those other departments.

1:22:15.530 --> 1:22:28.40
Arduengo, Sebastian
Yeah. So just really quickly to go through our efforts on the mental health front. So in total 8, which is our insurance.

1:22:29.160 --> 1:22:30.330
Arduengo, Sebastian
The all of our insurance laws.

1:22:31.140 --> 1:23:1.350
Arduengo, Sebastian
We have a mental health parity statute that says that health insurers can't impose any rate, term or condition on the coverage of mental health services that's not imposed for physical health services, and we interpret this quite broadly. So one of the projects that we're we're working on in this regard is we're working with Dana Robson at the Department of Mental Health on a working group to identify.

1:23:1.630 --> 1:23:8.340
Arduengo, Sebastian
And remedy barriers to access for residential mental health services for children.

1:23:9.820 --> 1:23:18.990
Arduengo, Sebastian
We also worked with the Commissioner of the Department, Commissioner Haas, to identify.

1:23:20.690 --> 1:23:31.100
Arduengo, Sebastian
Prior authorization requirements for inpatient mental health treatment and after we met with the insurers.

1:23:32.360 --> 1:23:42.570
Arduengo, Sebastian
Blue Cross Blue Shield of Vermont, which was the only insurer that had such requirements for inpatient mental health services, agreed to drop those requirements.

1:23:43.930 --> 1:23:46.120
Arduengo, Sebastian
And I think that will be effective.

1:23:47.140 --> 1:23:52.970
Arduengo, Sebastian
Either soon or at the very least, by the beginning of 2023.

1:23:54.670 --> 1:23:57.20
Arduengo, Sebastian
And then I think lastly.

1:23:57.650 --> 1:24:2.440
Arduengo, Sebastian
We have a federal grant and one of the.

1:24:3.330 --> 1:24:18.160
Arduengo, Sebastian
One of the things that we're gonna try and deal with our grit is engage outside contractor to help our help standardize our insurance form review processes to be able to catch things like.

1:24:19.420 --> 1:24:22.230
Arduengo, Sebastian
That prior authorization requirement or.

1:24:22.440 --> 1:24:38.960
Arduengo, Sebastian
And different requirements for, say, antidepressants in an insurers formulary. That way we can we can address those things at the form filing stage instead of waiting for a consumer complaint to come in.

1:24:43.80 --> 1:24:45.820
Hentcy, Kathleen (she/her)
Thank you very much, Sebastian. Thank you for jumping in.

1:24:47.970 --> 1:24:55.70
Hentcy, Kathleen (she/her)
So can we talk a bit ina about the equity it, do you see health care reform?

1:24:56.390 --> 1:24:58.770
Hentcy, Kathleen (she/her)
Directly addressing equity issues.

1:25:2.120 --> 1:25:2.580
Saroyan, John M
We.

1:25:1.200 --> 1:25:3.960
Hentcy, Kathleen (she/her)
In any way, or how you see it, yeah.

1:25:6.680 --> 1:25:36.890
Saroyan, John M
I I talked previously as well as Doctor Levine mentioned that we work with federal partners in what's called the Innovation Center and it is called the Center for Medicare and Medicaid Innovation. It was created by the Affordable Care Act. It was created by the Affordable Care Act specifically to test new payment and delivery models in Medicare. And without Medicare needing an active Congress in order to pay.

1:25:37.130 --> 1:25:50.280
Saroyan, John M
Differently than fee for service, Medicare is very original. Medicare is very steeped in and works in the confines of a rigid fee for service reimbursement model.

1:25:51.460 --> 1:25:56.960
Saroyan, John M
The Center for Medicare and Medicaid Innovation has prioritized.

1:25:57.600 --> 1:26:2.830
Saroyan, John M
Where it can all payer innovation projects again for that.

1:26:3.540 --> 1:26:30.510
Saroyan, John M
And with that rationale that with all payers aligned in providing, for example, a more flexible payment and all payers aligned with the in terms of what's important to deliver for quality and outcomes and value, if all payers are contracting with healthcare providers in a similar way, then the signal, the incentive.

1:26:31.400 --> 1:26:37.860
Saroyan, John M
The flexibility will be much more accommodating to achieve that outcome.

1:26:39.650 --> 1:26:50.570
Saroyan, John M
The Center for Medicare and Medicaid Innovation has recently issued what's like a called a strategy refresh. They've been around for, you know.

1:26:51.290 --> 1:27:9.420
Saroyan, John M
10 plus years and really kind of operating at a pretty good clip for the last decade in terms of testing and promoting new payment and delivery models. But in their strategy refresh, they really put a a different emphasis on.

1:27:10.350 --> 1:27:11.940
Saroyan, John M
Uh, HealthEquity.

1:27:12.940 --> 1:27:35.340
Saroyan, John M
For their models as well as emphasizing how models can help to address health related social needs and that equity and addressing health related social needs should be at the center of innovative payment and delivery models.

1:27:36.390 --> 1:27:56.990
Saroyan, John M
And again, I think there are some ways that we have already identified about more flexible payment and delivery models that can better promote HealthEquity because it allows for providers in the system of care to have flexibility in meeting.

1:27:57.950 --> 1:27:59.620
Saroyan, John M
Uh in meeting?

1:28:0.460 --> 1:28:14.180
Saroyan, John M
Needs for all patients and even for focusing on where there are health disparities as well. And so I think we.

1:28:15.550 --> 1:28:18.120
Saroyan, John M
Will continue to.

1:28:19.50 --> 1:28:26.540
Saroyan, John M
Work with that central with that central to our exploration of moving forward with.

1:28:27.340 --> 1:28:38.580
Saroyan, John M
Continuing payment reform in the state of Vermont, and we're also looking to the expertise at the Innovation Center as well as they've reframed.

1:28:39.140 --> 1:28:41.540
Saroyan, John M
Uh, they are thinking around.

1:28:42.320 --> 1:28:49.130
Saroyan, John M
HealthEquity, but I I think that it is also a work in progress for them as it is for us.

1:28:50.580 --> 1:28:54.880
Saroyan, John M
But maintaining it as central is is what we will be doing.

1:28:56.330 --> 1:28:57.800
Hentcy, Kathleen (she/her)
Great. Thank you.

1:28:58.760 --> 1:29:9.120
Hentcy, Kathleen (she/her)
Umm, while we're getting close to to wrapping up before I go back to Allison and and Doctor Levine, ina, I'm wondering if.

1:29:10.300 --> 1:29:15.980
Hentcy, Kathleen (she/her)
You can give us some suggestions for our you know, we have these four work groups.

1:29:17.40 --> 1:29:27.70
Hentcy, Kathleen (she/her)

Focus one focused on primary care, one on pediatric care, one on funding and alignment of performance measures and then the workforce development work group.

1:29:28.760 --> 1:29:33.740
Hentcy, Kathleen (she/her)
Are there? What could we keep in mind about health care reform?

1:29:34.560 --> 1:29:46.60
Hentcy, Kathleen (she/her)
As as we go forward with those work groups on this Council can are there? Are there ways that you think that that it could inform our work?

1:29:46.850 --> 1:29:47.800
Hentcy, Kathleen (she/her)
Specifically.

1:29:50.0 --> 1:29:54.330
Saroyan, John M
I mentioned that concept of a shared interest payment for.

1:29:54.930 --> 1:29:57.500
Saroyan, John M
Like a a group of providers.

1:29:59.310 --> 1:30:14.730
Saroyan, John M
And that shared in interest payment could potentially be bridging providers that are not necessarily working under the same payment model, but could link providers that are in different payment models. So for example, there could be a link.

1:30:15.350 --> 1:30:28.30
Saroyan, John M
For between providers working in a particular hospital payment model, like a global payment model for hospitals and providers working the designated agency.

1:30:29.190 --> 1:30:30.760
Saroyan, John M
System for example.

1:30:31.230 --> 1:30:40.610
Saroyan, John M
And that are not a part of necessarily that hospitals global budget and and payment. And when I think about.

1:30:41.300 --> 1:30:53.180
Saroyan, John M
That linkage, the linkage point, would be again relative to the triple AM. What are we? Why? Why are we linking and what is the better health?

1:30:53.910 --> 1:30:57.0
Saroyan, John M
And the better care that we're looking to deliver.

1:30:57.680 --> 1:31:3.110
Saroyan, John M
And that seems like a place that is ripe for discussion in the quality.

1:31:3.890 --> 1:31:9.920
Saroyan, John M
Metrics Ohh work group. For example. What where are some?

1:31:10.920 --> 1:31:14.10
Saroyan, John M
Where can we identify some Poe?

1:31:14.770 --> 1:31:23.630
Saroyan, John M
Co priorities and outcomes that we would potentially want to be unified in accomplishing across.

1:31:24.360 --> 1:31:28.980
Saroyan, John M
And between provider types and systems, that's that's one example.

1:31:30.590 --> 1:31:31.120
Saroyan, John M
And.

1:31:32.410 --> 1:31:40.40
Saroyan, John M
I don't know if if Doctor Saroyan has some ideas about the primary care and the pediatric spaces where. Thanks. Thanks Gina.

1:31:41.160 --> 1:31:44.420
Saroyan, John M
I I would be curious to know from the work groups.

1:31:44.630 --> 1:32:10.610
Saroyan, John M
And Kathy, if if they have any, if Members have any experience with Community health teams, if they have experience with aspects of blueprint programs through their lives or through their professional work on what they would like to see more of, if anything, that would be helpful to me. And and the the leaders of the group could certainly just contact me directly with what they're hearing and.

1:32:12.190 --> 1:32:13.270
Saroyan, John M
That would be very helpful.

1:32:24.230 --> 1:32:26.180
Saroyan, John M
Oh, sure, yes. Yeah.

1:32:13.900 --> 1:32:30.380
Hentcy, Kathleen (she/her)
Oh, that's interesting. OK. And and the facilitators also if it's. However, it's easiest if you wanna funnel things through me or if you just wanna send them the documents, you're wrong. It doesn't matter how. However, it's easy. That's great. OK.

1:32:31.420 --> 1:32:33.430
Hentcy, Kathleen (she/her)
Well, as we start to wrap up.

1:32:33.550 --> 1:32:34.80
Hentcy, Kathleen (she/her)
Ohm.

1:32:34.820 --> 1:32:35.740
Saroyan, John M
You wanna say something?

1:32:35.640 --> 1:32:38.390
Hentcy, Kathleen (she/her)
I wanted to ohh I'm sorry. Was there anything else?

1:32:40.40 --> 1:32:41.420
Hentcy, Kathleen (she/her)
From either Edna or.

1:32:40.550 --> 1:32:41.670
Saroyan, John M
And we wanted to speak.

1:32:45.830 --> 1:32:46.480
Hentcy, Kathleen (she/her)
Ohh.

1:32:42.610 --> 1:32:52.330
Saroyan, John M
Speaking to the workforce group, which I know Allison is in, is involved with and mentioned. You know, I think there are also lots of opportunities there and.

1:32:54.440 --> 1:32:55.540
Saroyan, John M
Considering like.

1:32:56.310 --> 1:33:16.460
Saroyan, John M

Flexibility again in multidisciplinary teams and how teams are supported to work at the top of their licenses and and to have members of their team that are appropriately providing care and services consistent with their training and ability.

1:33:18.850 --> 1:33:20.660
Hentcy, Kathleen (she/her)
Great. OK. Thank you.

1:33:21.300 --> 1:33:26.430
Hentcy, Kathleen (she/her)
I didn't mean to cut you off. Where there are other points that no. OK, great.

1:33:27.900 --> 1:33:35.880
Hentcy, Kathleen (she/her)
So I wanted to ask Doctor Levine and Allison, as we're wrapping up and thank you everyone, that this has been of long.

1:33:35.960 --> 1:33:45.350
Hentcy, Kathleen (she/her)
Umm in depth discussion. I'm sure everyone's feeling tired. We're going to take a break next before we do that.

1:33:46.790 --> 1:33:58.900
Hentcy, Kathleen (she/her)
Doctor Levine, Allison, are as you're reflecting on this conversation today, are there a couple of critical points that that you're going to keep in mind? Are there takeaways that really?

1:34:0.340 --> 1:34:1.400
Hentcy, Kathleen (she/her)
Got your attention?

1:34:3.230 --> 1:34:5.170
Hentcy, Kathleen (she/her)
Doctor Levine, do you wanna go first?

1:34:8.960 --> 1:34:9.970
Levine, Mark
No, but I will.

1:34:10.260 --> 1:34:10.730
Hentcy, Kathleen (she/her)
Yes.

1:34:11.990 --> 1:34:13.340
Hentcy, Kathleen (she/her)
I was gonna say you could say no.

1:34:17.850 --> 1:34:18.440
Levine, Mark
You know.

1:34:21.370 --> 1:34:26.420
Levine, Mark
I I hate to reduce it to this, but I think one of the take home points is it's really complicated.

1:34:27.10 --> 1:34:27.430
Hentcy, Kathleen (she/her)
Yeah.

1:34:28.290 --> 1:34:36.160
Levine, Mark
And if people came into the meeting thinking it's really complicated, I'm not sure that they're gonna leave the meeting thinking it's less complicated.

1:34:37.360 --> 1:34:39.670
Levine, Mark
That's not a failure of the presentations.

1:34:41.310 --> 1:34:47.100
Levine, Mark
That's where we are as a country and as a state.

1:34:47.970 --> 1:34:49.290
Levine, Mark
Umm so.

1:34:51.50 --> 1:34:51.420
Hentcy, Kathleen (she/her)
Yeah.

1:34:50.820 --> 1:34:52.420
Levine, Mark
Can I say but.

1:34:52.350 --> 1:34:52.650
Hentcy, Kathleen (she/her)
Yeah.

1:34:53.730 --> 1:34:57.210
Levine, Mark
But one thing I'm I'm kind of hearing, but I I think.

1:34:58.410 --> 1:35:2.270
Levine, Mark
Everyone would appreciate a little more of we've covered many models.

1:35:3.700 --> 1:35:7.750
Levine, Mark
And these models are integrated models, Needless to say.

1:35:8.730 --> 1:35:17.770
Levine, Mark
Some of them are kind of sponsored by the federal government, like the CBHC. So if I were to be bold and say.

1:35:18.610 --> 1:35:21.440
Levine, Mark
These things can be paid for well, certainly.

1:35:22.560 --> 1:35:30.750
Levine, Mark
That model can be paid for because we've had a number of our sites receive grants to accomplish that.

1:35:31.510 --> 1:35:35.480
Levine, Mark
And and they're part of a federal scheme, if you will.

1:35:36.330 --> 1:35:42.400
Levine, Mark
Umm, but then there are other things that we haven't really focused on as much today.

1:35:44.40 --> 1:35:47.670
Levine, Mark
But you know we we use the word whole health, you know liberally.

1:35:48.280 --> 1:35:48.770
Hentcy, Kathleen (she/her)
Yeah.

1:35:49.620 --> 1:35:54.70
Levine, Mark
But that, of course, embodies a number of models that we've seen.

1:35:54.770 --> 1:35:57.400
Levine, Mark
That other places have pulled off.

1:35:58.900 --> 1:36:17.670
Levine, Mark
So I'm gonna leave with the impression that Vermont can pull it off as well, but we haven't really spent as much time being very specific to Vermont's kind of own special mix of waivers and innovation deals and what have you as to how.

1:36:18.150 --> 1:36:43.240
Levine, Mark

Uh. Multiple different models that we've discussed would actually become feasible if we as a Council were to sort of recommend them at at the final hour, so to speak, of our existence. But I'm gonna come away thinking that there is a lot of innovation that is feasible.

1:36:44.10 --> 1:36:45.80
Levine, Mark
And.

1:36:46.850 --> 1:36:55.870
Levine, Mark
Anything we do as a Council is gonna have to be highly informed by those who understand health care reform.

1:36:56.530 --> 1:37:7.760
Levine, Mark
Umm. And we wouldn't want to be making recommendations that don't really pass the litmus test for this is actually something you could pull off.

1:37:9.110 --> 1:37:13.200
Levine, Mark
But I'm I'm feeling optimistic about that, not not pessimistic.

1:37:15.220 --> 1:37:18.630
Hentcy, Kathleen (she/her)
Thank you. Yeah, that's that's great. Thank you very much.

1:37:20.230 --> 1:37:22.270
Hentcy, Kathleen (she/her)
Allison. What? What do you think?

1:37:25.260 --> 1:37:27.470
Krompf, Alison (she/her)
I too am optimistic and overwhelmed.

1:37:28.330 --> 1:37:30.30
Krompf, Alison (she/her)
Umm, I think.

1:37:30.720 --> 1:37:34.930
Krompf, Alison (she/her)
One thing that I got out of listening to eat and doctor, sorry and talk is that.

1:37:35.760 --> 1:37:50.130
Krompf, Alison (she/her)
There has been so much work done already that this isn't some brand new concept and we're just getting started like we've been at this a long time. There's been a larger vision. There's just a lot of pieces to put together as we work towards it.

1:37:51.560 --> 1:37:58.540
Krompf, Alison (she/her)
And I think two things come to mind. For me. One is it goes back to the piece about medical model.

1:37:59.180 --> 1:38:27.730
Krompf, Alison (she/her)
Umm, because I think now that I've had some time to think through that kind of that question you asked Kathy and then a a credit to Ward Nile. He sent me an e-mail with some other thoughts that really started making me think about what that actually means when people who have been stigmatized in the past go to get their care at places that they've known to be more diagnostic based. There's a concern about what that's going to look like for them. And will it be? What's your symptom? I've got this medication.

1:38:28.710 --> 1:38:38.950
Krompf, Alison (she/her)
And so it's twofold. I think it's about and learning about what the Community health teams do and how there's more of this like personal outreach and thoughtfulness about what somebody's goals are and how do we work together.

1:38:39.890 --> 1:39:10.220
Krompf, Alison (she/her)
How can we make sure more mental health is being done in those spaces that they're thinking it about it in a really trauma informed way and they're seeing alternatives to medication as a potential path for folks. And we've seen that in population health, right? We're not trying to go straight to blood pressure medication. We're trying to go to other, you know, act actions and healthy lifestyles first. So that's something I think we need to talk more about on just making sure that.

1:39:10.340 --> 1:39:16.970
Krompf, Alison (she/her)
We're all moving in that direction. I'm both sides. Whether you walk in the door to mental health agency or health care agency.

1:39:18.540 --> 1:39:46.680
Krompf, Alison (she/her)
And the second piece for me is I've seen it in our move from fee for service to more value based care. It's like so exciting. Everybody loves the change and yet providers are caught in the middle because we can never really quite cross over the line. And there's still this sort of straddling like some things are still in fever service, some things are still in a case rate. The example of FQHC's and CCHC.

1:39:48.20 --> 1:40:16.730
Krompf, Alison (she/her)
Mary Kate Mullen pointed out the other day. One Samsa and once hersa so like even that has two sets of parents who need to be talking and you filter that down to our middle management of that and trying to get it out the door and you've got agencies and organizations twisting themselves in knots trying to pull down funding wherever they can. And so to me, it's just reiterates the need for groups like these to come together and say, OK.

1:40:16.830 --> 1:40:22.900
Krompf, Alison (she/her)
What's your list of? What's your accountable to? What's your list? What types of providers are necessary to get there?

1:40:23.730 --> 1:40:33.20
Krompf, Alison (she/her)
And then making sure we're giving the people serve that chance to shout from their rooftops. Hey, like, I'm still not getting what I need. And so then we tweak it.

1:40:33.880 --> 1:40:34.210
Hentcy, Kathleen (she/her)
Yeah.

1:40:34.260 --> 1:40:39.990
Krompf, Alison (she/her)
And so again, it's just that's the way that it comes to mind is I'm thinking of this push and pull.

1:40:41.670 --> 1:40:46.30
Krompf, Alison (she/her)
And the speed by which state government goes, I like to move fast. I love change.

1:40:58.760 --> 1:40:59.70
Hentcy, Kathleen (she/her)
Yeah.

1:40:46.670 --> 1:40:59.180
Krompf, Alison (she/her)
You can barely rewrite a manual by the time the rules have changed, and that leaves people pretty confused about how to do the work as well. So like there is a pacing to this, I think we need to be somewhat realistic about that. People can keep up with.

1:40:59.880 --> 1:41:20.330
Hentcy, Kathleen (she/her)
Yeah. Great. Thank you for that. I just wanted to back up. You used Samsa and hersa for those not fluent in these acronyms, saying they're both federal agencies. Samsa is the substance abuse, mental Health Services Administration, HERSA is the health research.

1:41:20.940 --> 1:41:24.260
Hentcy, Kathleen (she/her)
And you know, helped me here, health research.

1:41:28.920 --> 1:41:29.470
Saroyan, John M
Uh.

1:41:25.210 --> 1:41:29.990
Hentcy, Kathleen (she/her)
Services administration or what's hersa? Or maybe Susan Barrett could jump in.

1:41:30.870 --> 1:41:33.760
Saroyan, John M
Help rural rural is the R.

1:41:34.560 --> 1:41:35.670
Saroyan, John M
For herself.

1:41:37.450 --> 1:41:37.840
Hentcy, Kathleen (she/her)
Then.

1:41:36.930 --> 1:41:38.750
Saroyan, John M
Resources. Resources.

1:41:34.930 --> 1:41:40.150
Mary Kate Mohlman
No, it's uh, this is Mary Kate. It's health resources and services administration.

1:41:41.810 --> 1:41:42.380
Saroyan, John M
Wrong.

1:41:40.10 --> 1:41:57.800
Hentcy, Kathleen (she/her)
There we go. There we go. Thank you, Mary Kate. So two different federal arms. Samsa overseas, the certified Community Behavioral Health Clinic model and hersa overseas, the federally qualified health care centers, which we heard about in January.

1:41:58.930 --> 1:42:9.270
Hentcy, Kathleen (she/her)
Thank you so much. I I I've been involved with healthcare reform very much on the periphery, but I've been around it.

1:42:9.990 --> 1:42:12.420
Hentcy, Kathleen (she/her)
For at least a decade.

1:42:13.520 --> 1:42:25.320
Hentcy, Kathleen (she/her)
And I learned so much today. It's just really helpful. You, you all and really stuck in there. This has been long and thank you to everyone, all the participants who have stuck with us.

1:42:26.150 --> 1:42:32.360
Hentcy, Kathleen (she/her)
We are going to take a 15 minute break now. You should all have in your.

3:18:7.190 --> 3:18:16.390
Hentcy, Kathleen (she/her)
Umm, so we're just we're gonna do. We'd like to hear briefly from each work group just to a very brief.

3:18:16.510 --> 3:18:22.140
Hentcy, Kathleen (she/her)
Ohm report out of your discussion where you're at.

3:18:24.60 --> 3:18:34.990
Hentcy, Kathleen (she/her)
And again, if people had follow up questions, comments about the discussion this morning about health care reform, please do send those to me and I I will follow up.

3:18:35.440 --> 3:18:44.870
Hentcy, Kathleen (she/her)
Umm, so why don't we get started? Allison and Kayla, do you mind reporting out first? Just a really brief idea of how it went and.

3:18:47.550 --> 3:18:54.820
Krompf, Alison (she/her)
Yeah, I will tell you. OK, jump in a we're just having all the blunt conversations. We're just.

3:18:57.50 --> 3:18:57.520
Ganguly, Kheya (She/Her)
Yeah.

3:18:56.910 --> 3:18:58.360
Krompf, Alison (she/her)
Getting at it about like.

3:18:58.360 --> 3:18:59.290
Hentcy, Kathleen (she/her)
Success.

3:19:1.330 --> 3:19:7.230
Ganguly, Kheya (She/Her)
Yeah, I feel like we've been working with each other for like a year on this stuff said. We've just hit the point where we're just like.

3:19:8.510 --> 3:19:11.880
Ganguly, Kheya (She/Her)
I know this idea might not be popular, but we need to talk about it.

3:19:12.400 --> 3:19:15.690
Hentcy, Kathleen (she/her)
That's great. Good, good, good, great.

3:19:15.340 --> 3:19:27.140
Krompf, Alison (she/her)

Yeah, I'll say the what's nice, where our group are trying to leverage work from other groups. OK, are being vice chair of the HealthEquity group. There's some work there that we've identified, you know, in the list of trainings that need to be done.

3:19:28.240 --> 3:19:28.680
Hentcy, Kathleen (she/her)
Well.

3:19:28.70 --> 3:19:29.670
Krompf, Alison (she/her)
You don't need to create a new list.

3:19:30.400 --> 3:19:30.770
Krompf, Alison (she/her)
Ah.

3:19:30.150 --> 3:19:30.990
Hentcy, Kathleen (she/her)
Cool, yeah.

3:19:37.360 --> 3:19:38.330
Hentcy, Kathleen (she/her)
Mm-hmm.

3:19:31.980 --> 3:19:40.740
Ganguly, Kheya (She/Her)
We're just gonna cut and paste and put the references in like what page do the report it came from and everything with the link so that we could say from the HealthEquity report.

3:19:42.300 --> 3:19:42.600
Hentcy, Kathleen (she/her)
Right.

3:19:41.830 --> 3:19:49.820
Krompf, Alison (she/her)
Now in the main summary for us is workforce is a limited resource. We need to treat it as such. So how do we have some hard conversations about?

3:19:51.490 --> 3:19:53.640
Krompf, Alison (she/her)
What services can be provided where and?

3:20:3.860 --> 3:20:4.470
Hentcy, Kathleen (she/her)
Yes.

3:19:55.470 --> 3:20:5.910
Krompf, Alison (she/her)

You know, drawing the lines for that, but those lines are permeable. What do we call it with Kathy? And we're talking to doctor within permeable cells, like people in and out of them.

3:20:5.830 --> 3:20:6.860
Hentcy, Kathleen (she/her)
Cell walls.

3:20:8.560 --> 3:20:12.770
Hentcy, Kathleen (she/her)
Right, right. Yeah, that's great. OK. Anything else?

3:20:14.650 --> 3:20:35.920
Krompf, Alison (she/her)
We've divided some sections and given some work with people's hats, I will say it's been nice to have leave do have Dan Toll in our group and he's educated us on, you know, broadening what peer supports mean. I think we all had different ideas, but having him be able to be the one to put the words down instead of us interpreting I think is going to be helpful.

3:20:36.700 --> 3:20:38.40
Hentcy, Kathleen (she/her)
That's great. OK.

3:20:39.10 --> 3:20:39.530
Hentcy, Kathleen (she/her)
Thank you.

3:20:40.610 --> 3:20:44.180
Hentcy, Kathleen (she/her)
Umm, Laurel, you're next on my screen. Do you mind?

3:20:44.970 --> 3:21:1.950
Omland, Laurel (She/Her)
Nope, I don't. Unfortunately, Haley had to hop off for a different meeting. So it's it's me and our great pediatric subgroup members who are here today. We had done quite a bit of work in some of our recent subgroup meetings on our section of the report, so.

3:21:3.250 --> 3:21:13.400
Omland, Laurel (She/Her)
We decided to actually debrief the conversation that we heard this morning, and Doctor Saroyan, John was in our group, which was great. So I'll show some of those notes with you, Kathy.

3:21:14.370 --> 3:21:14.870
Hentcy, Kathleen (she/her)
Thank you.

3:21:15.760 --> 3:21:24.810
Omland, Laurel (She/Her)
And I would say the discussion kind of aligned some with with what we have put forward. So in our subgroup and in the report what we are highlighting is some of the work we did around.

3:21:26.120 --> 3:21:36.970
Omland, Laurel (She/Her)
Clarifying some key guiding principles for pediatric healthcare when we're talking about integration. So what's kind of the unique aspects for children, youth and families that need to be considered when we're talking about integrated care?

3:21:38.80 --> 3:21:55.470
Omland, Laurel (She/Her)
So we have a quite a few of those identified. We have a draft logic model around what integrated care and the children's world could look like starting first with primary care. I thought it was maybe we would do something similar for other settings, but that was our first one.

3:21:57.570 --> 3:21:59.340
Omland, Laurel (She/Her)
And then we talked about.

3:22:30.890 --> 3:22:31.200
Hentcy, Kathleen (she/her)
Hello.

3:22:1.630 --> 3:22:31.460
Omland, Laurel (She/Her)
The importance of and maybe this is overlap. You know the another group, but it just came up as we were talking about it. How do you measure the integration itself, not just the outcomes and impacts with patients, but and how through one of our recent federal grant projects we were able to work with our evaluator out of V Chip who took a tool around measuring. It's like a self-assessment tool for providers to get a sense of like where are you in integration work?

3:22:31.580 --> 3:22:40.900
Omland, Laurel (She/Her)
And it was tailored for the pediatric world. Our evaluator helped tell her it. So that was something that we made make note of. And then we just put forward some recommendations around.

3:22:41.390 --> 3:22:46.240
Omland, Laurel (She/Her)
And what we think need to be the areas of focus to get started.

3:22:47.240 --> 3:22:55.950
Omland, Laurel (She/Her)
I think there's plenty of work cut out for us. Some of our conversation today about this morning's discussion was around.

3:22:57.110 --> 3:23:3.980
Omland, Laurel (She/Her)
You know, there's still that driving need for a diagnosis and the pros and cons of that.

3:23:4.820 --> 3:23:5.370
Omland, Laurel (She/Her)
Umm.

3:23:6.420 --> 3:23:10.410
Omland, Laurel (She/Her)
And we talked about that in relation to certain populations, especially early, early childhood.

3:23:10.560 --> 3:23:26.340
Omland, Laurel (She/Her)
And and you know, we're like I said, the pros and cons. I won't rehash the conversation. And then how to really think about Wellness activities and if we're talking about a workforce and Allison's comment this morning about kind of sharing roles potentially.

3:23:40.930 --> 3:23:41.270
Hentcy, Kathleen (she/her)
Yeah.

3:23:27.130 --> 3:23:43.810
Omland, Laurel (She/Her)
You know how? How could we lift up examples where that's happened? Well, and have those be understood and known by others? Because I think pockets of us know some good examples. But how do we spread that more broadly? So that was just a couple Nuggets from our conversation this morning.

3:23:44.760 --> 3:23:45.190
Hentcy, Kathleen (she/her)
Great.

3:23:44.910 --> 3:23:45.250
Omland, Laurel (She/Her)
Thanks.

3:23:46.0 --> 3:23:46.970
Hentcy, Kathleen (she/her)
Yeah. Thank you.

3:23:48.40 --> 3:23:51.230
Hentcy, Kathleen (she/her)
Ohh Steve, you're next on my screen.

3:23:52.490 --> 3:23:53.330
DeVoe, Stephen (He/Him)
Awesome. Thank you.

3:23:54.700 --> 3:24:7.90
DeVoe, Stephen (He/Him)
Yeah, we had a very robust discussion and I think it highlights the word I kept using was multidimensionality of you know thinking about funding and the alignment of funding and.

3:24:7.730 --> 3:24:21.870
DeVoe, Stephen (He/Him)
Performance measures and really, what are we measuring and like world to use? The example that you just used, you know, are we measuring integration and the level of integration, are we measuring the processes, are we measuring the outcomes related to into?

3:24:23.350 --> 3:24:55.580
DeVoe, Stephen (He/Him)
But then you know, there was a few different folks that really highlighted the limitations related to accessing data and then data the accompanying or associated data sources, specifically electronic health records, electronic medical records. Having those systems talk to each other or the the barriers that there are that exist for those systems to talk to each other, especially as it relates back to care coordination. So if you know somebody is being transferred to a different system of care, let's say.

3:24:55.650 --> 3:24:57.260
DeVoe, Stephen (He/Him)
For example, at Dartmouth Hitchcock.

3:24:58.520 --> 3:25:28.310
DeVoe, Stephen (He/Him)
You know, how is that care coordination and how are those patient records, you know, interfacing with four folks. So really again thinking about those types of things. It was also discussed which I think again is an opportunity for us as a work group is having people from the Community peer community particularly sitting at the table for these discussions because if we're thinking about outcome measures, you know how is that impacting patient or client care.

3:25:29.320 --> 3:25:36.200
DeVoe, Stephen (He/Him)
And you know the impact of of that care on those individuals, their families, they're natural support.

3:25:37.500 --> 3:25:43.750
DeVoe, Stephen (He/Him)
A really, again thinking about you know is sitting at the table and ensuring that there's a level of.

3:25:45.920 --> 3:25:46.560
DeVoe, Stephen (He/Him)
You know when.

3:25:47.280 --> 3:25:48.320
DeVoe, Stephen (He/Him)
Thinking about these.

3:25:49.720 --> 3:25:50.320
DeVoe, Stephen (He/Him)
Being as in.

3:25:52.740 --> 3:25:53.120
DeVoe, Stephen (He/Him)
Umm.

3:25:55.590 --> 3:26:0.360
DeVoe, Stephen (He/Him)
Yeah. We talked a little bit about kind of the shared interest measures specifically HEDIS measures.

3:26:0.440 --> 3:26:31.390
DeVoe, Stephen (He/Him)
Umm and I shared about for the Department of Mental Health and our new payment model that we've adopted follow up after hospitalization and how there's other organizations like one care for example, that's also tracking that. So I think again it's an opportunity for us to look at those measures that are being collected across the state that have, you know, physical and mental health implications. But then again, you know, thinking about it from a process improvement standpoint.

3:26:32.310 --> 3:26:43.340
DeVoe, Stephen (He/Him)
You know, any metric has a process associated with it. So how do we ensure that there's some level of studying happening around those processes, you know, with the ultimate goal of trying to?

3:26:44.570 --> 3:26:47.130
DeVoe, Stephen (He/Him)
Ultimately, improve outcomes as a whole.

3:26:48.550 --> 3:26:48.910
Hentcy, Kathleen (she/her)
OK.

3:26:52.410 --> 3:26:52.790
Hentcy, Kathleen (she/her)
Yeah.

3:26:49.430 --> 3:26:54.720
DeVoe, Stephen (He/Him)
So yeah, and I OK. I raised her hand. I don't know. OK. If I said something that sparked so.

3:26:55.590 --> 3:26:57.740
Ganguly, Kheya (She/Her)
Actually, everyone did something. That's smart.

3:26:58.460 --> 3:26:58.910
DeVoe, Stephen (He/Him)
Right.

3:26:58.200 --> 3:27:8.230
Ganguly, Kheya (She/Her)
Umm, one of the things I think we need to think about when we're looking at these things is the structural racism, peace cause we're still talking about processes, data structures.

3:27:9.940 --> 3:27:14.760
Ganguly, Kheya (She/Her)
And thinking outside the box sometimes, like if we're going to measure outcomes.

3:27:15.890 --> 3:27:21.930
Ganguly, Kheya (She/Her)
How are we going to measure outcomes for bipop folk? Or maybe someone from who's a refugee?

3:27:22.860 --> 3:27:28.530
Ganguly, Kheya (She/Her)
That we we might be able to measure traditional outcomes that we are used to measuring.

3:27:29.160 --> 3:27:47.210
Ganguly, Kheya (She/Her)
But how do we account for those other pieces and how do we integrate practices that are culturally sensitive, such as Chinese medicine, maybe for someone or some some of those things that that's a conversation. I think we all should be having in our groups and.

3:27:48.240 --> 3:27:51.750
Ganguly, Kheya (She/Her)
How are we really thinking about this? Or, you know, are we being very?

3:27:53.500 --> 3:27:58.570
Ganguly, Kheya (She/Her)
White centered or are we really trying to integrate some new stuff in?

3:27:59.640 --> 3:28:0.580
Ganguly, Kheya (She/Her)
Based on.

3:28:1.650 --> 3:28:2.660
Ganguly, Kheya (She/Her)
You know HealthEquity.

3:28:5.60 --> 3:28:5.680
DeVoe, Stephen (He/Him)
It could.

3:28:5.410 --> 3:28:5.890
Ganguly, Kheya (She/Her)
That's all.

3:28:4.630 --> 3:28:6.830
Hentcy, Kathleen (she/her)
You're in. Thank you, Kyle. It's helpful.

3:28:13.340 --> 3:28:13.680
Hentcy, Kathleen (she/her)
Yeah.

3:28:18.300 --> 3:28:18.600
Hentcy, Kathleen (she/her)
Yeah.

3:28:22.720 --> 3:28:23.90
Hentcy, Kathleen (she/her)
Yeah.

3:28:6.330 --> 3:28:30.780
DeVoe, Stephen (He/Him)
Could not agree more Archaea. And again, Kay and I have had this discussion but around you know what qualifies or constitutes data and include being inclusive of both quantitative and qualitative data, and especially given that some groups have oral histories, some groups have written history and are we being as inclusive as possible as a state and ensuring that all data you know has an equal spot at the table so.

3:28:31.470 --> 3:28:32.70
DeVoe, Stephen (He/Him)
Thanks for saying.

3:28:31.690 --> 3:29:2.700
Hentcy, Kathleen (she/her)
Well, and I just wanna thank you Kaya because to say because you mentioned before you start to speak that it it was several people said things that that made you want to speak and and it's something we've got to keep bringing up and talking about because it's it's not how we've been doing business. So it it doesn't mean any kind of bad intent on anyone's part. It's just that it's not how we've been doing business you know traditionally so I think it's it's well worth just.

3:29:2.790 --> 3:29:5.640
Hentcy, Kathleen (she/her)
Keep anyone keeps saying it.

3:29:5.300 --> 3:29:10.80
Ganguly, Kheya (She/Her)
I'll be I'll be the squeaky wheel. I always have. It feels like it's swollen.

3:29:9.390 --> 3:29:18.160
Hentcy, Kathleen (she/her)
Well, and I'm just encouraging others. You think you know, say, hey, we're where's equity in here, where we please, you know, keep bringing it up. So thank you.

3:29:19.160 --> 3:29:19.560
Hentcy, Kathleen (she/her)
And.

3:29:18.720 --> 3:29:21.880
Alexis McGuiness (Guest)
And I'm still a squeaky wheel, too. Over here. I'm just.

3:29:21.990 --> 3:29:22.240
Alexis McGuiness (Guest)
He's.

3:29:21.570 --> 3:29:22.270
Hentcy, Kathleen (she/her)
Let's go ahead.

3:29:23.80 --> 3:29:27.40
Hentcy, Kathleen (she/her)
I'm Sam and you were working, I think with Cheryl.

3:29:27.910 --> 3:29:34.260
Sweet, Samantha (She/Her)
Yeah, I was with Cheryl today. Thank you, Cheryl, for taking notes julies on vacation, so.

3:29:35.130 --> 3:29:42.540
Sweet, Samantha (She/Her)
I'm just gonna give you a few high level of points that we had today.

3:29:43.160 --> 3:30:12.810
Sweet, Samantha (She/Her)
Umm, so we did talk about a little bit about measures we touched on of how do you measure a person's life. And so that was a good discussion we had around that. And one point of clarity we had is a comment was made early on about we won't see the return on the investments for generations and actually that's actually not true. Return on investments are usually seen within a few years.

3:30:13.160 --> 3:30:14.250
Sweet, Samantha (She/Her)
And so.

3:30:15.430 --> 3:30:15.880
Sweet, Samantha (She/Her)
Umm.

3:30:17.380 --> 3:30:17.720
Sweet, Samantha (She/Her)
Yeah.

3:30:20.950 --> 3:30:21.340
Sweet, Samantha (She/Her)
No.

3:30:22.460 --> 3:30:23.210
Sweet, Samantha (She/Her)
Ohh.

3:30:24.740 --> 3:30:25.0
Sweet, Samantha (She/Her)
Yeah.

3:30:14.200 --> 3:30:26.380
Hentcy, Kathleen (she/her)
On Sam, could I just interrupt you for a second? I'm sorry. I just wanted to. I didn't say your primary care, OK. I just wanted to make sure it's primary care. So I'm sorry, go ahead.

3:30:25.920 --> 3:30:27.670
Sweet, Samantha (She/Her)
That's OK, that's totally fine.

3:30:30.690 --> 3:30:45.190
Sweet, Samantha (She/Her)
So some high level points that we discussed today, we don't want to create a separation of systems between mental health and physical health. And there was a discussion around CBHC's and.

3:30:47.880 --> 3:30:51.670
Sweet, Samantha (She/Her)
Even though the intent is not to separate, is it?

3:30:52.600 --> 3:31:13.570
Sweet, Samantha (She/Her)
With CBHC, could that happen even more? So we talked about specialty care just like a cardiologist. You go to see a cardiologist in a building. Mental health. You go to a CBHC for a specialty service. So we touched on that.

3:31:16.460 --> 3:31:34.20
Sweet, Samantha (She/Her)
We also discussed the need, the need for trauma informed coaches within primary care, as well as making sure that it's part time work. A lot of people look for part time work and not full time and so how can we influence that?

3:31:36.580 --> 3:31:53.970
Sweet, Samantha (She/Her)
Services should be available wherever the individual is most comfortable going. We need a place like I said for specialty care, but then a place for someone to go back to once that specialty care is no longer needed at that level. So.

3:31:55.110 --> 3:32:10.60
Sweet, Samantha (She/Her)
They potentially could be connected to a peer within a primary care office, but go to a CBC for the specialty care and then return to the primary care once that service is no longer needed.

3:32:12.20 --> 3:32:22.630
Sweet, Samantha (She/Her)
But also how do we as a group build continue to build bridges and or break down barriers to having the?

3:32:23.460 --> 3:32:24.190
Sweet, Samantha (She/Her)
Care.

3:32:24.990 --> 3:32:32.0
Sweet, Samantha (She/Her)
On interrupted. So we want to make sure that there is coordination of care.

3:32:39.370 --> 3:32:39.780
Hentcy, Kathleen (she/her)
Umm.

3:32:34.700 --> 3:32:49.870
Sweet, Samantha (She/Her)
More work needs to happen around prevention. We need to have funding and and other things to go upstream to prevent a lot of work is being done now on the crisis level.

3:32:51.190 --> 3:32:59.730
Sweet, Samantha (She/Her)
We talk a lot about the mobile crisis and alternatives, CD and emergency rooms and and that's all crisis care. But how do we?

3:33:1.90 --> 3:33:9.780
Sweet, Samantha (She/Her)
How do we get further upstream and make sure those services are in place so people don't go further downstream?

3:33:10.730 --> 3:33:11.240
Sweet, Samantha (She/Her)
Umm.

3:33:13.160 --> 3:33:18.990
Sweet, Samantha (She/Her)
Your support needs funding, which we talked about is an initiative with with NDMH.

3:33:20.140 --> 3:33:21.110
Sweet, Samantha (She/Her)
And so.

3:33:22.580 --> 3:33:26.490
Sweet, Samantha (She/Her)
Making sure that there is funding to support the work appears.

3:33:28.340 --> 3:33:35.230
Sweet, Samantha (She/Her)
And then it was brought up about could we explore peers within the Community health team settings?

3:33:35.920 --> 3:33:37.280
Sweet, Samantha (She/Her)
As opposed to.

3:33:38.780 --> 3:33:45.250
Sweet, Samantha (She/Her)
Being embedded from a DNA into a primary care, but actually being part of the Community health team.

3:33:47.40 --> 3:33:53.450
Sweet, Samantha (She/Her)
Is there a way of that this peer could reduce stigma in these settings?

3:33:56.150 --> 3:33:56.750
Sweet, Samantha (She/Her)
Those with the.

3:33:58.260 --> 3:34:1.340
Sweet, Samantha (She/Her)
Biggest points I think I would bring up right now.

3:34:2.360 --> 3:34:6.10
Hentcy, Kathleen (she/her)
Great. OK. Thank you. Sounds like a lot of.

3:34:6.950 --> 3:34:16.880
Hentcy, Kathleen (she/her)
I I'm very impressed after the morning that we did that you folks went into those were groups and produced all this is really great. Thank you.

3:34:17.520 --> 3:34:18.130
Hentcy, Kathleen (she/her)
Umm.

3:34:19.360 --> 3:34:25.970
Hentcy, Kathleen (she/her)
Are there any other comments from the work group? See anybody else wanted to before we go into public comment.

3:34:26.660 --> 3:34:29.690
Hentcy, Kathleen (she/her)
Other facilitators have anything they want to add or.

3:34:30.970 --> 3:34:31.350
Hentcy, Kathleen (she/her)
No.

3:34:33.270 --> 3:34:40.440
Hentcy, Kathleen (she/her)
So we have time now set aside for public comment, so please raise your hand if there's anyone.

3:34:41.830 --> 3:34:49.190
Hentcy, Kathleen (she/her)
Who has anything they'd like to add, and I'm just gonna be quiet for ohh good. Here we go. David Silverberg, please.

3:34:50.40 --> 3:34:57.370
Hentcy, Kathleen (she/her)
And we are recording this, David, so that so you know you're you're comments, we will have a record of your comments.

3:34:58.670 --> 3:34:59.260
David Silverberg
OK, great.

3:34:58.110 --> 3:35:0.680
Hentcy, Kathleen (she/her)
For our use to take forward, yeah.

3:35:1.920 --> 3:35:18.870
David Silverberg
Great. Thank you for giving me the time to speak today. I'm here today as a parent and I just. I'm not sure if this is the correct forum to address these matters, but I was trying to bring awareness to the lack of first episode, early psychosis treatment in Vermont.

3:35:19.950 --> 3:35:25.760
David Silverberg
And on the pairing of a daughter who's struggled for four years now with schizophrenia.

3:35:26.760 --> 3:35:34.230
David Silverberg
And her circumstances have been the exact reasons that other states have developed the first episode early psychosis programs.

3:35:35.450 --> 3:35:39.110
David Silverberg
Just because there's a huge delay in treatment and experience.

3:35:39.970 --> 3:35:43.510
David Silverberg
And it's it's really been just such a tough process to go through.

3:35:44.420 --> 3:35:53.530
David Silverberg
Umm, in Vermont we have the Soteria house, which is more visit group living for schizophrenia and then we have the Brattleboro retreat.

3:35:54.290 --> 3:35:54.700
David Silverberg
Which?

3:35:55.370 --> 3:36:6.920
David Silverberg
Just kind of medic, you know, medically medicates and treats schizophrenia. But other than that, there's a a major lack of resources. And so recently I've had to.

3:36:7.800 --> 3:36:15.590
David Silverberg
It took me 5 months to press Medicaid to allow us to go to Massachusetts General Hospital and do a consult there.

3:36:16.540 --> 3:36:19.440
David Silverberg
And they have several programs that they've.

3:36:20.400 --> 3:36:25.950
David Silverberg
Made us aware of, and there's a certain model of treatment called the navigate model.

3:36:26.830 --> 3:36:29.90
David Silverberg
And so I'm just here to bring those.

3:36:31.190 --> 3:36:36.270
David Silverberg
There's programs to awareness in Vermont and and hopefully somewhere down the line they can be integrated.

3:36:38.50 --> 3:36:40.350
David Silverberg
It it's a, it's hard thing to go through with it.

3:36:41.130 --> 3:36:43.320
David Silverberg
As a parent to watch your kids suffer.

3:36:44.880 --> 3:36:48.560
David Silverberg
In psychosis, they're they're very confused and it's just.

3:36:49.260 --> 3:36:53.720
David Silverberg
As a parent to not have resources or have to find somebody that's experiences.

3:36:54.690 --> 3:36:58.810
David Silverberg
Is extremely hard. It's it's like having a child with autism with no care.

3:37:0.220 --> 3:37:5.480
David Silverberg

So I appreciate your time today and I and I hope that maybe in the future guys can bring this to your agenda.

3:37:7.640 --> 3:37:17.560
Hentcy, Kathleen (she/her)
Thank you very much, David, I'm I'm very sorry to hear of the struggles that you've had, Allison. I saw that you did. You wanna say something?

3:37:19.30 --> 3:37:45.680
Krompf, Alison (she/her)
Yeah, I think a thanks for coming. And I do think bar hope is to hear about practices when you go to other places outside of our state and you're seeing anything that looks promising with this is exactly what we want people to do. And I am just going to ask if you'd be open to a follow up, we might be able to talk about what region of the state that you're in, which could offer some additional, you know, insights and what services and supports are near nearby.

3:37:46.510 --> 3:37:50.530
David Silverberg
Definitely I give you my e-mail or phone number if you'd like.

3:37:52.500 --> 3:37:52.920
Hentcy, Kathleen (she/her)
And.

3:37:52.230 --> 3:37:52.930
Krompf, Alison (she/her)
Yeah, I think.

3:37:53.680 --> 3:37:54.210
Hentcy, Kathleen (she/her)
Well, go ahead.

3:37:54.150 --> 3:37:59.890
Krompf, Alison (she/her)
We I think we have it. You have you. You reached out, right? Right. David via e-mail.

3:38:1.310 --> 3:38:1.980
David Silverberg
Ohh yeah.

3:38:1.340 --> 3:38:3.60
Krompf, Alison (she/her)
To say that you want today.

3:38:2.700 --> 3:38:3.970
David Silverberg
I did, yes.

3:38:5.50 --> 3:38:5.270
David Silverberg
Yeah.

3:38:3.710 --> 3:38:36.860
Krompf, Alison (she/her)
That is, you write. OK, great. Then we have it. So. Umm, but I think it's good that you escalated the question of public forum because now more people can can hear about the option. We do have some funding in a in a different there's another Advisory Council that looks up mental health block grant dollars. I won't get into what all of that means federally, but it just means there is a bucket of funding that is dedicated to this type of resource, of helping early episodes like Cosis. And so, you know, there's another kind of forum we can take this conversation to and get people's input and maybe do some.

3:38:39.500 --> 3:38:39.930
David Silverberg
Great, I.

3:38:36.960 --> 3:38:41.790
Krompf, Alison (she/her)
Search into other types of approaches. Is that what you were gonna say? Did I steal your Thunder?

3:38:43.400 --> 3:38:57.750
DeVoe, Stephen (He/Him)
No, you did not steal my Thunder. But but yeah, David. Again, thank you so much for sharing that. And yeah, I had actually been notified by our policy director, Nicole Distasio. And I think it was you. So I would love to be able to connect offline.

3:38:58.810 --> 3:39:0.220
DeVoe, Stephen (He/Him)
And just again hear more.

3:39:1.420 --> 3:39:3.730
DeVoe, Stephen (He/Him)
That it really would help us inform.

3:39:5.10 --> 3:39:6.720
DeVoe, Stephen (He/Him)
With that, with that fun thing.

3:39:7.910 --> 3:39:10.380
David Silverberg
I love to be involved anyway I can, so I appreciate it.

3:39:12.250 --> 3:39:13.210
Hentcy, Kathleen (she/her)
Thank you, David.

3:39:14.400 --> 3:39:14.790
David Silverberg
Thank you.

3:39:19.940 --> 3:39:20.800
Hentcy, Kathleen (she/her)
Are there other?

3:39:22.520 --> 3:39:24.670
Hentcy, Kathleen (she/her)
Public comments.

3:39:30.130 --> 3:39:30.410
Tessler, Julie
No.

3:39:27.440 --> 3:39:34.50
Hentcy, Kathleen (she/her)
I'm just going to be patient and wait just a little bit. I want to make sure people have a chance. I'm sorry. Did someone speak?

3:39:48.60 --> 3:39:53.330
Hentcy, Kathleen (she/her)
Well, if there aren't other public comments, I wanted to turn back to.

3:39:55.20 --> 3:40:2.630
Hentcy, Kathleen (she/her)
Allison and Doctor Levine were. Was there anything that you wanted to say before we adjourn?

3:40:5.530 --> 3:40:11.100
Krompf, Alison (she/her)
Doctor Levine is still on. I will just say I think we started out in this like.

3:40:11.750 --> 3:40:30.300
Krompf, Alison (she/her)
Broad conceptual where we trying to go and now I think we're much more in the nitty gritty and I just wanna honor and and thank folks for sitting in that, Umm, you know, it's a little less of a fun curious exercise and more of a digging in and really like.

3:40:31.30 --> 3:40:35.330
Krompf, Alison (she/her)
Putting a lot of energy into this and you just it takes a lot of thinking and.

3:40:36.190 --> 3:40:44.100
Krompf, Alison (she/her)
If the long day and just watching people show up to this over and over and over again is really.

3:40:44.940 --> 3:40:45.390
Krompf, Alison (she/her)
Hopeful.

3:40:46.150 --> 3:40:49.50
Hentcy, Kathleen (she/her)
Yes, thank you. Yeah, yeah.

3:40:46.440 --> 3:40:49.150
Krompf, Alison (she/her)
So that's my comment doctor line.

3:40:49.940 --> 3:40:52.760
Levine, Mark
Yeah, just to thank people for enduring so alone.

3:40:58.520 --> 3:40:58.950
Hentcy, Kathleen (she/her)
Yeah.

3:40:53.240 --> 3:41:3.400
Levine, Mark
Uh, there's important. This is a very long meeting, but we accomplished a lot and I think just hearing the work group reports.

3:41:4.720 --> 3:41:7.50
Levine, Mark
Is pointing us in the right direction for sure.

3:41:7.910 --> 3:41:11.190
Levine, Mark
Umm, I do want people to understand that.

3:41:12.300 --> 3:41:12.990
Levine, Mark
While.

3:41:14.50 --> 3:41:31.940
Levine, Mark
Councils meet and continue to meet the work of state government continues to go on, so there's still a lot going on in this area of mental health, substance use and overall health integration.

3:41:33.480 --> 3:41:36.600
Levine, Mark
And we'll try to bring some of that to the group.

3:41:37.700 --> 3:41:39.330
Levine, Mark
Because as you all know.

3:41:39.910 --> 3:41:41.680
Levine, Mark
Umm we have.

3:41:42.510 --> 3:41:46.200
Levine, Mark
New Year's not too far away and there'll be a new legislative session.

3:41:47.340 --> 3:41:47.900
Levine, Mark
And.

3:41:54.150 --> 3:41:54.310
Hentcy, Kathleen (she/her)
Yeah.

3:41:48.870 --> 3:42:17.140
Levine, Mark
Once the legislative session gets going, it assumes a life of its own as well, so there'll be some parallel tracks in terms of what the administration is looking to do and is trying to recommend. What this Council is going to formally recommend and what the legislature has its own ideas and a lot of new membership and what it may recommend. So just be prepared for.

3:42:18.720 --> 3:42:23.500
Levine, Mark
Even more activity, as these next few months go by.

3:42:27.500 --> 3:42:27.820
Hentcy, Kathleen (she/her)
It's.

3:42:25.20 --> 3:42:27.940
Levine, Mark
They don't keep our lives much more interesting, believe me.

3:42:29.960 --> 3:42:31.590
Hentcy, Kathleen (she/her)
Yeah, just a little more uncertainty.

3:42:33.550 --> 3:42:37.340
Ganguly, Kheya (She/Her)
Isn't that an old Chinese curse? May you live in interesting times.

3:42:37.750 --> 3:42:38.400
Hentcy, Kathleen (she/her)
Yeah.

3:42:38.260 --> 3:42:39.790
Alexis McGuiness (Guest)
Yeah. No, but.

3:42:39.190 --> 3:42:56.980
Hentcy, Kathleen (she/her)
What we do, we do. Ohh. Thank you so much. Both Allison and Doctor Levine and everyone again, as I said, when we reconvened, I I just, I'm so appreciative of everyone's not just your time. Everyone is so engaged and it is really wonderful.

3:42:57.940 --> 3:42:59.0
Hentcy, Kathleen (she/her)
Very hopeful so.

3:43:2.620 --> 3:43:3.30
Hentcy, Kathleen (she/her)
We.

3:43:4.80 --> 3:43:4.890
Hentcy, Kathleen (she/her)
Our e-mail.

3:43:5.530 --> 3:43:6.70
Hentcy, Kathleen (she/her)
Of the temp.

3:43:8.220 --> 3:43:9.130
Hentcy, Kathleen (she/her)
And please do.

3:43:10.880 --> 3:43:11.310
Hentcy, Kathleen (she/her)
Comment.

3:43:13.360 --> 3:43:14.350
Hentcy, Kathleen (she/her)
After I send.

3:43:17.260 --> 3:43:19.550
Hentcy, Kathleen (she/her)
And have a great rest of your day.

3:43:20.320 --> 3:43:21.40
Alexis McGuiness (Guest)
Thank you.

3:43:21.700 --> 3:43:22.140
DeVoe, Stephen (He/Him)
Thank you.