# MENTAL HEALTH INTEGRATION COUNCIL PEDIATRIC SUBGROUP

## DATE: JANUARY 17, 2023

Microsoft Teams meeting

**Join on your computer, mobile app or room device**

Click here to join the meeting

Meeting ID: 285 053 309 195
Passcode: V2CS4i

Download Teams | Join on the web

**Or call in (audio only)**

+1 802-552-8456,,281061344# United States, Montpelier

Phone Conference ID: 281 061 344#

Find a local number | Reset PIN

Learn More | Meeting options

## ATTENDANCE

Workgroup Members

☐ Heather Bouchey, Deputy Secretary, Agency of Education

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

☐ Mike Fisher, Office of the Health Care Advocate

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

☒ Dr. Logan Hegg, UVMMC psychologist, pediatric integration

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

☒ Ward Nial, Representative, National Alliance on Mental Health

☒ Dr. Sara Pawlowski, UVMMC psychiatrist, pediatric integration (alternate)

☐ Dr. John Saroyan, Blueprint for Health

☐ Ilisa Stalberg, VDH Maternal Child Health

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

☒ Chelsea Cooley, DMH, Pediatric Mental Health Care Access Program Manager

**Previous workgroup members:**

Dr. Harris Strokoff, Representative, Blue Cross Blue Shield (ended)

Julie Parker, Blue Print for Health (ended when Dr. Saroyan joined)

Kate LaRose VDMH, Pediatric Mental Health Care Access Program Manager (ended 9/9/2022)

Connie Schutz, DMH CHILD integration grant (ended on 9/30/2022)

Facilitators

☒ Laurel Omland, DMH Child, Adolescent & Family Unit (CAFU)

☐ Haley McGowan, DMH CAFU Medical Director

Members of the Public

☐ Stephanie Winters, AAPVT/VTAFP/VMS

**Regrets from:** Haley, Breena, Ilisa, Mike

**Agenda**

## WELCOME, AGENDA, GROUP GUIDELINES & INTRODUCTIONS

We welcomed each other, reviewed the meeting agenda, reminded ourselves of the group agreements and introduced ourselves.

1. Good tight facilitation to help keep focus.
2. Act as a learning community. Use info as foundation to move forward.
3. We recognize our organizational hats and are intentional about when we have it on and when to remove it to help advance our work together. We all bring professional backgrounds, training and personal experience.
4. Ask the tough questions, it's okay to challenge the norm
5. Be aware that an action item can be resolved later, keep track of action items, assign, revisit, resolve.
6. Patience with technology, especially in hybrid mode
7. Be present, try to minimize multi-tasking
8. Listen to others' perspectives, think about it, before launching into what you want to say. not just waiting to talk

**Invitation:** *What group norm will you especially focus on today?*

## WARM UP

**Invitation:** *The MHIC and its subgroups are charged with not just putting forward recommendations but taking action steps. With one other person in a breakout room (random pairs), share an action you have taken in the past 3 months that you could attribute to the discussions of this workgroup.*

Got thinking about school clinics, why are there not psychologists and/or psychiatrists in those clinics? Exploring that, asking questions.
Well Child visits are covered, not MH well visits. Yet, get paid more to see child individually than as a family – disincentive in reimbursement rates for individual vs family care. Want to incentivize systems/family approach to care. Medicaid & BCBS family codes reimburse less than indiv codes.

Thinking of work in sub-group and applying concepts with friends (families or practitioners) – worry about absence of private practice community. System seems to incentivize people to move in that direction (to private practice) to provide MH care. Structural incentives could be addressed.

## MOVING FROM RECOMMENDATIONS TO ACTIONS

1. **What 2 recommendations do you feel most connected to?**
   **Enter # (can include sub-recommendation) into chat**
   Logan: 2b & 7b
   Chelsea: 8 & 5. 2b
   Dillon: 2d & 5
   Sara: 4
   Ward: 5
   Laurel 2, 8 (and 4)

   No one identified 6, only parts of 7
2. **Identify action steps for those recommendations.**

- 2b:
  - Introducing evidence-based research in meetings with representatives from VT BCBS and Medicaid. (I'm new, perhaps this is already happening.)
    - Gather national evidence, gather state-level data
    - Identify who to meet with
  - Logan: Upcoming Touchpoints training; think about pivoting the role of psychology in primary care towards prevention/early intervention; keeping an eye out for federal dollars for these types of programs in primary care and early ed
    - Touchpoints has personal/family impact to reorient to strengths
    - Heard there may be federal NOFO coming soon to support this work
    - Early childhood work – home-visiting programs do a lot of coaching in the home with parent/child dyad. May be more challenging if in PCP office setting b/c of amount of visits that occur (weekly). How to partner with, enhance relationships, ensure stability of those providers who are doing that work. Understand what family needs and can access
- for 2d -- Dillon could facilitate sharing of how one DA successfully partnered with primary care office as a model for future partnerships
  - would this be an example of an existing national model or tie to shared principles?
- 5) Coordinated service plans seem like an opportunity. The first action could be to talk to those involved with CSPs and find out what their needs are. Ie Rather than assume MH integration is the most important missing piece.
  - CSP Guidance document could add language about when & how to invite PCP repetitive to offer input on CSP. PCP care coordinator, Blueprint rep, nurse
    - Dillon: I've had very positive outcomes on teams with the Blueprint person attending CSPs. I think CSPs get close to the Whole Health model we heard

            about last year -- identifying the kid's overall goals, whether they are health related or not
        - Workgroup to brainstorm about this topic – could do this with LIT Coordinators
            - Laurel connect with Cheryle on this.
    - Educate Blueprint teams about CSP process, what value it has for children, how they could be involved.
        - Laurel connect with Cheryle. Start with Julie Parker
- 2a: want to do some thinking with this team about hub for VT-specific info
    - Expand VT CPAP website?
        - Project Teach: https://projectteachny.org/ - good model website to do what we might be interested in doing for VT.
    - Laurel will put onto Feb agenda to explore this further – want others who are absent today to be in this discussion
        - Who is target audience? Is it primary care?
        - content categories
        - what entity might be best situated to hold this
- 3: consider educational pathway for undergraduates in psychology, education, health – broaden idea of who is workforce, how to recruit and use educational pathways
    - Look at undergrad programs, interest in creating modified majors – learn through community how to do behavioral health integration.
    - Community Health Worker initiative currently underway – someone, AHEC? – is creating definitions for this role. Someone could talk to whomever is doing this –
        - Dillon will look into who is entity and will contact them to understand structure, communicate desire to broaden BA-level workforce and are there points of intersection with their work?
- 4: evaluate existing ped/perinatal psych-consult services.
    - PMHCA & STAMPP teams invested in taking this forward. Currently gathering data for the VT specific pilots to see impact, can combine with the national data for such services. Then need to identify contacts with Blueprint, Medicaid, BCBS to discuss sustainability options.
    - Creating access pathways for services on levels of care for collaborative care so not on waitlist for months. Step-up and step-down. Connect psych consults, collaborative care, need to tie to other forms of access could help to demonstrate value of it. E.g. psych consult occurred, determined needed psych consult, rather than put on psych waitlist have those who are referred from psych consult to go directly to psychiatry service list. Allow to move more seamlessly through levels of care. Bidirectional access pathways in collaborative care – increase agreed upon pathways and workflows. "freeze & thaw slots"
        - Action to start: Greta, Sara, Maya Strange talking about who is on that pathway, improve access. Start with VCCYF. Then consider what other MH provides (private sector, what is role of DA)

- 7b: public messaging about available pathways to care – potential points for linkage between website concept (like Project Teach) which has referral info, is it available for anyone to access to find therapists… VT help link as another example.
    - Have Help Link people share lessons learned from conceptualization to current structure. And/or Help Me Grow? Discus further.
- 8: Ped measurement team – want to connect more with the Financial/Measurement team, where to begin?
    - Laurel connect w/ Steve to share more of our 1/10 breakout discussion/ review of the Finance/Measurement team's section of MHIC report. Are there places to link our efforts?

3. **Are any of these action steps more immediately do-able?**
   Included this above
4. **What to focus on with the recommendations within the group, outside of the group.**
   Included this above
5. **Some recommendations are things the group doesn't have the capacity to do, so who or where can it happen?**
    a. Maybe #6 Change Management recommendation b/c no one claimed connection.

## INVITING INPUT & QUESTIONS & THOUGHTS FROM THE PUBLIC

## TASKS BEFORE OUR NEXT MEETING

## CLOSE THE MEETING

**Our commitments before our next meeting:**

**Our timeline and next meetings:**
Next Meeting is February 21st