

Primary Care WG Notes

November 8, 2022

Present: Samantha Sweet, Nicholas Nicolet, Andy Pomerantz, Alexis McGuinness, George Karabakakis, Mary Kate Mohlman, Cindy Seivwright, Dr. Levine, Kelly Klein

Notetaker: Cheryle Wilcox

PART 1 – Health Care Reform discussion

What are your thoughts about health care reform? Where do you see linkages to your work? The Council's work?

- Return on investment—we need to define the term. Physicians may define it one way; patients another way. If we really build a whole health system, the payoff is generations down the road.
- Long-term concern—CCBHC improves access, but they have had very little impact on overall health. The risk of CCBHCs is that it further separates people with mental health needs from physical health care.
- We don't want to create a separate system for mental and physical health care. We have co-located staff from DAs at health providers. Those connections are really important. We don't need to wait for CCBHCs to integrate physical and mental health care. One point of clarity is that Return on Investments are seen within a few years not generations from now.
- About 60% of HCRS funding is not fee-for-service. It is case rates, waivers, and other bundled funding. Performance metrics are a part of this.
- How do we measure a person's life—individuals who end up homeless and living on the street because there are no places for them to live or be sheltered.
- Interagency and multi-disciplinary work is something mental health agencies have been doing. It is about making connections.
- Peer support workforce at HCRS:
 - peers in adult and residential programs, one of their peers did a presentation to medical providers about intentional peer support.
 - This work can't be billed so it comes out of their overall bottom line. However, with CCBHC funding this does get covered.
 - They are embedded in prevention coalition, crisis response, shelters and drop in centers.
 - They are expanding peer supports to children, youth and families programming.
 - About 4 months ago, they hired a peer support specialist in their Dev. Disabilities program.

- Peer support works with EMT and law enforcement in Hartford—the town pays half of this cost.
- Peer support is under resourced.
- Standing up Assertive Community Treatment Team.
- Need trauma-informed coaches; also need PT work for individuals early on in their healing.
- People need step by step guidance all along the way so they are a part of their healing.
- Services should be available wherever individuals are most comfortable going
- Need a place for a higher level of care for specialty; and a place to come back to when that specialty care is no longer needed. How do we build bridges or barriers across this care? People need to get the right care, at the right time and the right place. This helps to prevent individuals going into crisis.
- Need more prevention work – upstream to prevent avoid getting to the crisis level of care.
- Return on investment—we may see a monetary return, but it may not be in the medical sector. E.g. More people holding down jobs and paying income taxes, less people being homeless. AND, we don't always have the data systems set up to monitor this kind of return.
- Having the hospital and DA system it bifurcates the system of care-how do we link those more together—such as shared data systems, share staffing, etc. Break down the barriers to coordinating care.

Drafting the legislative report

- Last meeting discussed peer supports through DSU—training and requirements with recovery coaches.
- Recovery Coaches in the substance use world:
 - Recovery coaches are certified.
 - To do specialty work, there is additional training (working with pregnant/parenting moms, working in EDs).
 - Different levels of training and supervision.
 - There is also a requirement for having a certain time in their own recovery.
 - Recovery Coaches are not necessarily full-time.
 - Recovery Coaches started in the hubs.
 - Recovery Coaches are not in primary care settings.
 - There is a full-time unit at DSU (4 individuals) focused on recovery. This team supports Recovery Coaches, overdose prevention, harm reduction.
- Next part-what would this look like in a primary care setting?
- Peer supports need funding.
- Members did not know about any medical practices with peers presently.
- What do we see as the role of peers in medical settings?

- Exploring peers in community health team settings? Is that a way to move having more peers available. This could reduce stigma in these settings.
 - What would the job description look like? Just lived experience? Lived experience and they understand their role? What does onboarding look like? Peers who really know their own feelings and have their own network of supports.
- Do we feel like peers in primary care settings should be the focus of this group?
 - Peers are critical and essential without a doubt.
 - Also need to ensure peers are part of a system of care where they are getting the support they need. Having a network, supervision, etc.
 - Destigmatizing that addressing mental health is a normal part of care.
 - How to have warm hand offs.