MHIC Workforce Development NOTES:

IMD conversation – need to ensure everyone understands the nuance of what this means. The state has to phase down Medicaid reimbursement funding for any beds over 16 beds in a stand-alone psych facility where length of stay is over 60 days. This is part of the impetus for moving towards inpatient psych attached to medical facilities – which creates more integrated care opportunities.

Julie Tessler – Reported news that Medicare will start reimbursing other qualifications beyond LCSW. Can we get confirmation/documentation on this?

Dan Towle - SSDI – The way its set up a lot of people who want to work lose SSDI if they work – impacting the staffing crisis - Alison will bring this up with Thiffeen from Leahy's office for further discussion

CCHBC discussion: four federal grants – Rutland, HCRS -Windham, NKHS in NEK, Clara Martin Center Orange (They are on Year 2).

How will we develop and sustain an integrated care workforce to support FQHC's, expansion of HUB and Spoke, and CCBHC's?

Mary Kate-

- FQHC = HRSA; CCBC = SAMHSA
- Two separate entities marching on parallel tracks. I haven't seen them talking

Policy Academy follow up – Ask the SAMHSA folks if there is coordination there. Is staff level communication and cross-pollination happening? -Alison to ask SAMHSA, Mary Kate -HRSA

Mary Kate and Julie Tessler talked about the need for FQHC's and DA's to talk about where oversight aligns and how they can collaborate, potentially through DCO opportunities in CCBHC's to meet requirements through contracting with each other for services

Devon – mental health urgent care (howard center and UVMMC) is an example of a proposal looking at sharing staffing and resources to stand up an integrated resource

Discussed list of draft Outcomes on scorecard and areas of the January report people could take on:

Six Core Strategy training for emergency department staff and trauma informed care training – Goal to have training set up to be ready for implementation when ED's are stable enough to support training.

-**Devon** agreed to work on emergency dept integrated healthcare needs in report

-**Dan Towle** to focus on underdeveloped peer resources and where they could support gaps in the system

-**Mary Kate & Julie Tessler –** FQHC and CCBHC opportunities for aligned goals and shared or leveraged staffing through contracting. Are there differences in skill and license that are needed to serve mental health at a community mental health center versus an FQHC or other healthcare setting?

Julie Tessler & Alison - is serving adults with SMI and children and youth with SED equal to "specialty care" in healthcare? How do we message what is "best served" at a DA (or CCBHC). How do we develop workforce to best meet those needs. Recommendations for training up specialists – and compensating them for their specialty. To honor the complexity

Mary Kate & Julie Tessler – How do we reconcile the mission of healthcare to integrate mental health, and mental health to integrate healthcare. Can we lay out some guiding principles, current examples where things are working, and areas that need to be addressed – (1. reimbursement rates, Medicaid and non-medicaid for primary mental health being equitable with health – to support appropriate staff salaries to maintain quality and access. 2. Further exploring shared staffing, telehealth and other opportunities to leverage qualified staff without one entity hiring them all and depleting the other organizations.

Julie Tessler – Provided an overview of DA recruitment and retention – tuition reimbursement and loan repayment

We need to treat workforce like the limited resource that it is.

Integrated healthcare will take more than integrated clinical providers. We will need administrative entities who are trained in integrated reporting, analysis, billing, etc.