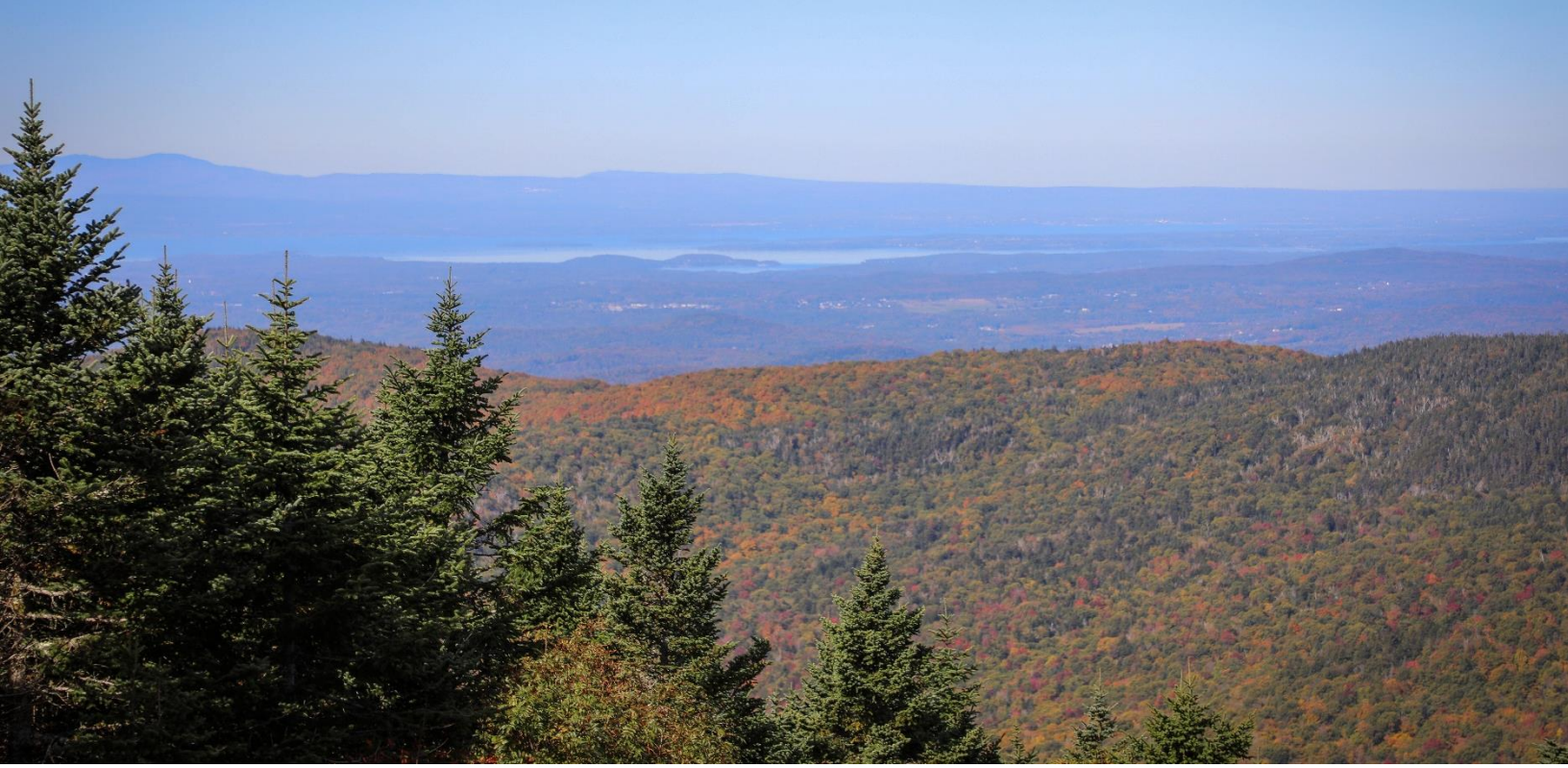

Vermont Departments of Health and Mental Health
Mental Health Integration Council

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Executive Summary

Achieving equitable care is a fundamental requirement in all healthcare reform, and across all domains. There must be equitable training, employment, reimbursement, and care. The recommendations of the Mental Health Integration Council are intended to be pursued through a lens of health equity.

The Mental Health Integration Council makes the following recommendations.

1. Establish accountability for reimbursement parity to ensure equitable access among all components of whole health care, (mental health, cardiology, radiology, etc.)
    a. Examine the use of public funds to sustain programs – both inpatient and outpatient -- that are under-reimbursed by private payers in direct contravention of Vermont law and lay out a clear path for reconciling private pay contracts with Vermont law.
    b. Define “specialty mental health care” appropriately and establish professional growth ladders to incentivize building experience and training in mental health specialty care. Leverage national expertise and virtual options to ensure better access to specialized clinical supervision.
    c. Ensure specialty mental health care is reimbursed at parity with specialty medical care. Current mental health parity laws do not address disparity in specialty care services.

2. Support and foster interprofessional teamwork. Researchers have found that successful integration of care requires everyone who works in and helps determine how care is provided to deeply understand all aspects of health care systems. There must be time for building relationships and sharing information and the people in those discussions must be reimbursed for their time. Interprofessional teamwork, is fundamental, as are shared financial systems[ii].
    a. Healthcare professional training paradigms should include cross disciplinary, team-based care and systems-based practice principles.
    b. Organizational accountability measures should include the responsibility to foster and keep up to date an interprofessional teamwork ethic/mandate.
    c. Performance measurement and reporting must be transparent, system-level cost management and quality outcomes must be rewarded, and accountability shared
    d. The process of integration must be recognized as a learning process that evolves, rather than a series of programmatic steps.

3. Commit to implementing a Whole Health approach to care across all providers. The Veteran's Administrations Whole Health Model [Whole Health Home (va.gov)] is a tested approach that provides implementation guidance. The National Academies of Sciences, Engineering and Medicine defines Whole Health as: … *physical, behavioral, spiritual, and socioeconomic wellbeing as defined by individuals, families, and communities. To achieve this, whole health care is an interprofessional, team-based approach anchored in trusted longitudinal relationships to promote resilience, prevent disease, and restore health. It aligns with a person's life mission, aspiration, and purpose. (NCBI 2023)*

    a. Applying the Whole Health approach to care requires redesign of services to join the best of both medical and mental health systems, while eliminating unrealistic limits on services, and the disease-and-symptom focus of traditional medical practice. Whole Health centers around what matters to you, not what is the matter with you. The approach considers factors that impact a person's wellbeing and utilizes non-clinical staff, including peer support specialists, to understand a person's values, needs and goals that can be incorporated into treatment planning.
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4. Continue to further increase development of what the federal government calls Certified Community Behavioral Health Clinics (CCBHC's) – which Vermont will rename to acknowledge the harmful language of the term "Behavioral." CCBHC's are intended to provide high quality community-based care for individuals experiencing mental health, substance use or co-occurring needs. A new federal opportunity to leverage enhanced match for achieving a high-quality standard of care for individuals with complex or intense mental health or substance use needs, CCBHCs require a broader set of screening and assessment, mobile crisis support for mental health and substance use needs, and a standard definition for care coordination across primary care and mental health. This model also requires the use of Peer Support Specialists, in line with the Whole Health Model, and intentional support specific to veterans, service members and their families. CCHBC's also establish a uniform method for calculating the cost of services, which may contribute to the development of more equitable and sustainable funding.
5. Support the ongoing expansion initiative of the Blueprint for Health

a. Partner with existing DA/SSA community mental health resources and collaboratively establish appropriate referral pathways.
b. Support expansion of the Community Health Teams' capacity to provide co-occurring mental health and substance use screening, brief intervention, treatment, and navigation to and coordination of services.
c. Support the strengthening of the Hubs for Medication Assisted Treatment for Opioid Use Disorder so that they too can provide services for co-occurring mental health and poly substance use disorder.
d. Support the expansion of the Developmental Understanding and Legal Collaboration for Everyone (DULCE) program, a team- and evidence-based model of care aimed at supporting the health and wellbeing of families throughout Vermont in the pediatric-serving medical home. This program specifically supports caregivers/families at a critical juncture in life and addresses the social drivers and ACE-producing (Adverse Childhood Experiences) circumstances (such as parent/caregiver depression, intimate partner violence, food and housing insecurity, substance use, and legal assistance) that will improve the future experience of the caregiver and child relationship. The expansion will support access to DULCE statewide for families with infants and it will be used as a framework for building the co-occurring CHT model for families with young children.

6. Use patient reported outcome measures to improve linkages between health and social services that support whole-person health across the lifespan and prevent disease.

    a. Incentivize health-related quality of life measures in a stepwise manner to be the primary measures for organizing patient care.

7. Ensure the work of Vermont's Health Equity Advisory Commission includes a focus on addressing the bias that exists among providers and staff against people with mental illness of any kind, and particularly those who experience psychosis.

    a. Support healthcare providers through training, and by embedding mental health clinicians and/or peer support specialists in primary care and emergency department settings to offer more comprehensive and person-centered options for treatment and to reduce involuntary procedures.

8. Recognize the role of employment as a key factor in mental health and health outcomes.

a. Address barriers to employment for vulnerable populations. Include training for mental health peer and community health worker teams in best clinical practices for supporting employment as a health outcome. On a population level, increased unemployment correlates with decreased overall health.

b. Address the reactive, fragmented cultures that have permeated healthcare and human service settings leading to burnout and moral injury for employees. Apply Trauma Informed Systems (TIS) policies and practices that support reflection in place of reaction, self-care instead of self-sacrifice and collective impact rather than siloed structures (TIS_Model.pdf (traumatransformed.org). The TIS model recommends training in reflective supervision and collaborative system approaches. Importantly, the model also fosters a culture of learning, and supports employees to experience meaning in their work. It is imperative to address the need for significant organizational culture shifts to attract and maintain a compassionate and skilled workforce to carry out the state's integrated healthcare vision.

9. Develop policies and practices for sharing staff between mental health and primary care practices to optimize care during times of mental health workforce shortages.

    a. The Vermont Child Psychiatry Access Program (CPAP) is an example of a program that has leveraged the limited psychiatry resources in the state to meet the needs of primary care providers for a specific population. Expansion of this program and exploration of this model applied to an adult population should be considered to mitigate existing psychiatric workforce issues.

    b. Encourage healthcare practices to hire mental health staff through DA/SSA's. Complex mental health needs are better managed by staff who are connected to a strong mental health supervisory network and who are well connected to referral options for specialized services provided by DA/SSA's. Contracting through DA/SSA's supports integration and optimizes the state's limited work force.

10. Support the development of mental health, substance use and other peer specialists who are routinely available in healthcare and other services, and that are equity-based, wellness-focused and provided in accordance with Vermont's laws regarding parity.

11. Streamline documentation and reporting.

a. Require state level leaders to evaluate the opportunity for shared reporting measures that support integrated healthcare goals.
b. Make targeted investments in clinical information specialists (people who work with clinicians to streamline the process of gathering information) who can be deployed to organizations for the purpose of evaluating documentation and reporting practices, with the goal of reducing administrative burden by 30% in three years.
c. Investigate the potential for organizing, merging and sharing data collection, management and analysis systems across all providers.

It is important to note that this report does not address other crucial social contributors to health, most notably housing as a foundational need for supporting health and mental health. However, the Mental Health Integration Council was a meaningful step towards engaging leaders in a process that builds off existing, successful efforts in integration in Vermont and reimagines a better collective and holistic healthcare system. The council recommends that all organizations working in the healthcare integration space commit to continued interprofessional teamwork and for the state to consider what entity exists that can help support this effort and hold us accountable to this goal.

Legislative Language

Sec. 4. MENTAL HEALTH INTEGRATION COUNCIL; REPORT

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

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

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

Introduction

The charge to the Mental Health Integration Council, formed as a result of legislation passed in 2020, is to help "to ensure that all sectors of the health care system actively participate in the State's principles for mental health integration." That charge essentially challenged the Department of Mental Health and its partners to push all providers of health care out of their silos and collaborate on integrating health care, state-wide and across all providers.

What is Integrated Care?

There is no single definition of "integrated care." As one paper noted, how integrated care is defined depends on the lens used to define that care. Four common definitions of integrated care appear in the appendix, but briefly, a health-systems based definition names the kinds of services managed and coordinated, sometimes across several sites; a manager's definition, on the other hand, calls out the processes for maintaining structures between stakeholders to coordinate care; a public health or social science perspective takes into account methods and models to address funding, administration, organization, service delivery, connectivity and more.

For the purposes of the Council, the most relevant common definition may be from the perspective of the person receiving or seeking care: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

Further, integration can be organized by type – horizontal (between health, mental health, social and other services), vertical (across primary, community, hospital, and tertiary care services), by sector (primary, community and secondary care providers), people-centered (care based in shared decision making across providers and services) and whole-system (includes public health to support both population based and person-centered care).

Through two years of discussion, the MHIC members of the Council and its four workgroups agreed unanimously that achieving equitable care must be a fundamental

requirement in all healthcare reform, and across all domains. The many needs of entire populations must be addressed for equity to be achieved. Addressing only certain groups, diseases or specific needs will not achieve equity and it will not lead to meaningful integration.

Why Integrated Care?

The integration of healthcare, often referred to as "integrated healthcare" or "integrated health systems," is a complex and multifaceted concept. It involves various strategies and approaches to bring together different components of the healthcare system, such as primary care, specialty care, mental health services, and social services, to provide more coordinated and patient-centered care. The evidence base for integrating healthcare is extensive and continues to evolve, but some key points and evidence are worth highlighting.

Health is not split between mental and physical health: Human health is integrated. Our physical health is inextricably linked to our mental health, and vice versa. In order to improve health outcomes, our health and social services systems must reflect this.

Improved Patient Outcomes: Numerous studies [i]have shown that integrated healthcare can lead to improved patient outcomes. For example, integrated care models have been associated with better control of chronic conditions, reduced hospital readmissions, and increased patient satisfaction.

Enhanced Access to Care: Integration can improve access to care (Druss, et. al. 2001), particularly for underserved populations. By removing barriers and providing a more holistic approach to healthcare, integrated systems not only reach individuals who might otherwise face challenges in accessing healthcare services, they reduce stigma associated with mental health care.[ii,iii, iv]

Cost Savings: Integrated care models can result in cost savings for healthcare systems and payers. By addressing health issues earlier and more effectively, integrated care can reduce the overall cost of care and reduce unnecessary hospitalizations.

Reduced Fragmentation: Fragmentation in healthcare can lead to inefficiencies and suboptimal care. Integration can reduce fragmentation by creating a seamless system in which various providers and services work together to address patients' needs.

> "Care integration matters[v] because patients with complex needs often receive care from multiple clinicians….A patient's care path may require visits to several care sites. Medicare beneficiaries see a median of two primary care physicians and five specialists each year, in addition to diagnostic, pharmacy, and other services.[4] Patients with multiple chronic conditions may visit up to 16 different physicians in a year.[4] On average, primary care physicians interact annually with 229 other physicians across 117 practices when providing care to their patients.[5] This high degree of fragmentation can result in clinicians not having access to relevant information when treating a patient (e.g., primary care physicians learn belatedly that their patient has been hospitalized, that an imaging scan is not available through the electronic health record, or that a patient did not fill a prescription) and has prompted calls to better integrate care."[6]

Prevention and Health Promotion: Integrated systems are more likely to prioritize preventive care and health promotion, helping individuals manage their health and well-being more effectively and avoid more serious health problems down the line.

Improved access to Mental Health and Substance Use Services: Primary healthcare is 'the first level of contact of individuals, the family and community with the national health system.' Primary care also tends to be the closest and easiest form of care and is not stigmatized as mental health care agencies often are.[vi]

Community-Based Approaches: Some integrated care models incorporate social services and community-based resources to address the health-related social needs, which can lead to improved health outcomes for patients.

Patient-Centered Care: Integrated care models prioritize patient-centered care, which focuses on the preferences and needs of individual patients, fostering a more engaged and satisfied patient population. Patient-centered care also tends to open the door to the use of peer specialists in care, which is associated with improved health[vii] and overall quality of life among those with serious mental illness and comorbid medical conditions.

Evidence-Based Practices: The development and implementation of integrated healthcare systems are based in evidence-based practices, ensuring that the care provided is grounded in research and best practices.

Overall, while the evidence for integrating healthcare is promising, the implementation and success of integrated care varies depending on local circumstances and the specific strategies used. Successful integration of health services will require on-going vigilance and dedicated efforts to maintain relationships, and to build new relationships with a willingness to challenge the status quo and question all aspects of care provision.

How will we Achieve Integrated Care?

Integrating the vastly complex health care systems means integrating vastly different cultures. It requires overcoming long-standing bias against those with mental illness. It requires dismantling the hierarchy prevalent in medical care, and to a lesser extent, in mental health care today to capitalize on the increasingly prevalent expansion of training and team-based care and systems-based competency in healthcare fields. There are favorable trends towards training in shared decision making and moving away from the historic paternalistic model. It will require new payment systems, new data collection and management. In many cases, it will require new office structures. True, full integration will require new training for all involved in care.

This magnitude of change will not be accomplished by any one model of integration or by an edict from on-high. Thirty years of work on integration, backed by six pieces of legislation in Vermont, have resulted in a patchwork of integration activities. While those examples of integration are valuable and have informed the discussions of the Council and therefore this report, it is clear that laying out one single simple pathway as a requirement for something as complex as healthcare system integration, while helpful, is not sufficient.

As a result, the MHIC approached the problem by providing structured discussions facilitated to invite all voices and viewpoints. Through two years of working meetings, both in full Council meetings and in workgroup meetings between the full Council gatherings, members had time to hear one another's concerns, ideas and suggestions. Each full council meeting carried the substance of those discussions forward. Fairly quickly, the idea of agreeing on principles of integration came to the fore. The members agreed that no matter how care is integrated, it must be based in equity, and be person-driven care that receives fair, sustainable reimbursement, utilizing robust IT systems and evidence-based/emerging practices.

Concurrently, the Council was hearing about the Blueprint for Health's (then proposed) expansion to provide co-occurring mental health and substance use screening, brief intervention, treatment, and navigation to and coordination of services. In addition, we learned about the Veteran's Administration's Whole Health model of care, which is a holistic, integrated care model developed by practitioners at the Veteran's Administration center in White River Junction. That model is based on providing a non-medical person (a peer specialist, or as Vermont's Blueprint for Health employs community health workers) as a first contact with all patients/clients, to establish the patient/client's goals and needs. There was general agreement among Council and Workgroup members that the Blueprint for Health and the Whole Health Model, together, would provide integration of care while improving outcomes in many areas.

Healthcare Reform

The work of re-forming our medical health services into an actual system that makes care easily accessible to all has been underway for decades. Vermont has long been a leader in this work, and an important milestone was the introduction of the Blueprint for Health in 2006. Some other notable points include the founding, in 2012, of OneCare Vermont, by the University of Vermont Health Network and Dartmouth Health. OneCare

Vermont, an Accountable Care Organization with the goal of linking providers and payers to deliver high-quality care and lower healthcare spending, received a $45 million grant from the Centers for Medicare and Medicaid (CMS) to test innovative payment and delivery system reform. Work has continued under the direction of Vermont's Healthcare Reform office, and supported by the Green Mountain Care Board.

Most, if not all reform efforts today, endorse the Quadruple Aim (QA). Introduced on a national policy level in 2008, the QA provides a framework that requires reform efforts to achieve 1) improved patient experience, 2) a focus on population health, 3) reduced costs, and 4) improved provider well-being. The recommendations of the MHIC support all four of these aims.

While these reform efforts have been important to the medical system, the focus on mental health services has lagged. Some date the first significant efforts to passage of the 1996 Mental Health Parity Act[viii]. Many providers in Vermont have made efforts to integrate health services, and there are many examples of care in Vermont that fall somewhere along the spectrum of integrated care. There are designated mental health agencies that have memoranda of understanding with local primary care offices to ensure that clients have a primary care provider. There are primary care practices with mental health professionals on staff or at least "co-located."

Many of those primary care practices are part of one of Vermont's 11 Federally Qualified Health Centers, which have offices operating in 73 locations. All of these practices either provide mental health services or are parties in memoranda of understanding that establish referral pathways to their community mental health agency. The University of Vermont Health Network, which employs more than 600 physicians and offers services through seven locations across Vermont and northern New York state, is implementing an integration model with the goal that "all advanced primary care should include full, easy on-site and telehealth access to mental health services, behavior change counseling for chronic disease management, and substance use disorder care including screening, medication-assisted treatment and counseling." And the Veteran's Administration (VA) in White River Junction developed an approach to integration that became national VA policy 15 years ago. More recently, the VA model of integrated care has become the platform for the VA's evolution to a patient-driven Whole Health model of care, and that model was the focus of an in-depth report by the National Academies of Sciences, Engineering and Medicine in 2023.

The focus on reform and integrating services as a key feature of that reform, continues to grow. The most recent federal initiative to incentivize reform is the AHEAD (Advancing All-payer Health Equity Approaches and Development) Model, developed by the Centers for Medicare and Medicaid Innovation Center. States must apply to participate in the initiative. The AHEAD model draws from experience with Vermont's ACO model as well as work done in Maryland and Pennsylvania (all supported by the CMS Innovation Center).

Participating states are required to hold providers responsible for delivering high-quality care, improving population health, curbing the growth of healthcare costs, increasing care coordination, and meeting health equity goals by supporting underserved patients. The AHEAD Model will provide the participating states with funding and support over the life of the initiative. Implementation grants will begin in 2024, and the program will run through 2034.

A central focus of the AHEAD model is increased investment in primary care, which will be expected to provide person-centered, whole health care. Mental health and substance use services are key, as are screenings and supports for health-related social needs (social determinants of health). According to CMS, AHEAD aims to increase resources to improve overall population health and "transform health care in their communities."

Vermont's participation in the AHEAD model is unknown at this point, but the message from CMS is clear – integration and equity remain key factors in healthcare reform. Whether Vermont participates in such a model or not, the desired transformation of healthcare in Vermont communities' hinges upon alignment between the goals of the new system and a reimbursement structure that incentivizes the needed and desired integration of mental health care.

An ideal vision of "Integrated Care"

The Council heard specifically about four methods of providing some level of integrated care – Federally Qualified Health Centers, Certified Community Health Clinics, Whole Health Model and the AIMS or Collaborative Care Model. There are many more models

of integration, but as the Council and Workgroup members discussed integration and how to achieve it, it became clear that time constrictions alone meant all – or even most - models could not be explored in-depth. More significantly, the Council agreed that since models overlap in many ways, and that no model is implemented exactly as designed, examining more than a few representative models seemed redundant.

Instead, the Council and Workgroup members named what integration should be. Rather than identifying practice models, the Council and Workgroup members agreed on a set of principles that should guide integrated care. The members agreed that no matter how care is integrated, it must be based in equity, person-driven care with choice, have fair sustainable reimbursement, robust IT and evidence-based/emerging practices.

This learning process is the work that the Council and additional members of four Workgroups (more on the Workgroups, below) have been engaged in over the past two years. The meetings were designed to allow the members and other participants to build relationship; and the focus has been on understanding of concepts and agreement on principles of integration. The Council has agreed on a draft vision of integrated care, and the workgroups focused on aspects of that vision.

The Workgroup Products

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

Council members are commissioners of state departments, the director of health care reform, members of the Green Mountain Care Board, CEOs or directors of partner agencies, members of advocacy groups or people with lived experience. While the members have been engaged in the meetings, few have time to do the work between meetings that is intended to initiate or support efforts to integrate care. In order to facilitate such efforts, the Council invited others to join one of four workgroups (see Appendix #2). The Workgroups are Primary Care, Pediatric Care, Funding & Alignment of Performance Measures and Workforce Development. Details of their work over the past 18 months can be found in Appendix #6.

The Workgroups spent many hours doing the work of relationship building and defining the parameters of the issues they are discussing. The range of results from the four

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

While the workgroups provided recommendations from their individual work, everyone reviewed and agreed to the full Council recommendations as laid out in this report.

Recommendations

The Council and its Workgroups met every other month from July 2021 through September of 2023 (the July 2023 meeting was cancelled due to historic flooding). In addition to continuing the work underway in the Workgroups (see summary below), the Council and Workgroup members used the remaining time to: 1) focus on system-level approaches to integration that embrace complexity and develop an appropriate evaluation methodology; 2) learn more about and discuss the development of peer specialists services in Vermont; 3) continue to better understand the role of the Accountable Care Organization, OneCare, and payment reform in furthering integration.

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The Mental Health Integration Council makes the following recommendations.

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2. Support and foster interprofessional teamwork. Researchers have found that successful integration of care requires everyone who works in and helps determine how care is provided to deeply understand all aspects of health care systems. There must be time for building relationships and sharing information and the people in those discussions must be reimbursed for their time. Interprofessional teamwork, is fundamental, as are shared financial systems[ii].
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    c. Investigate the potential for organizing, merging, and sharing data collection, management and analysis systems across all providers.

End Notes

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Appendix #1

Full Legislative Charge and List of Members

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

Sec. 4. MENTAL HEALTH INTEGRATION COUNCIL; REPORT

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

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

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

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

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

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

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

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

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

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

If applicable

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

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

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

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

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

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

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

(G) the Commissioner of Financial Regulation or designee; **Michael Pieciak, Commissioner**

(H) the Director of Health Care Reform or designee; **Ena Backus, Director of Health Care Reform**

(I) the Executive Director of the Green Mountain Care Board or designee; **Susan Barrett, Executive Director**

(J) the Secretary of Education or designee; **Heather Bouchey, Deputy Secretary**

(K) a representative, appointed by the Vermont Medical Society; **Dr. Simha Ravven**

(L) a representative, appointed by the Vermont Association for Hospitals and Health Systems; **Devon Green & Emma Harrigan**

(M) a representative, appointed by Vermont Care Partners; **George Karakabakis, CEO, Health Care & Rehabilitation Services**

(N) Vermont Association of Mental Health and Addiction Recovery representative; **Vini Emery**

(O) a Bi-State Primary Care representative - **Mary Kate Mohlman, Director Vermont Public Policy; Michael Costa, CEO Northern Counties Health Care**

(P) a University of Vermont Medical School representative; **Dr. Christian Pulcini**

(Q) the Chief Executive Officer of OneCare Vermont or designee; **Dr. Carrie Wulfman**

(R) the Health Care Advocate - **Mike Fisher**

(S) the Mental Health Care Ombudsman - **Lindsey Owen**

(T) a representative, appointed by the insurance plan with the largest number of covered lives in Vermont; BCBS; **Dr. Tom Weigel**

(U) two persons who have received mental health services in Vermont, appointed by Vermont Psychiatric Survivors, including one person who has delivered peer specialists services; **Karim Chapman & Dan Towle**

(V) one family member of a person who has received mental health services, appointed by the Vermont chapter of National Alliance on Mental Illness; **Ward Nial**

(W) one family member of a child who has received mental health services, appointed by the Vermont Federation of Families for Children’s Mental Health; **Sandi Yandow**

Appendix #2

Workgroups and their Membership

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

Integration of Primary Care

Facilitators

Julie Parker, Assistant Director, Blueprint for Health, Department of Vermont Health Access

Samantha Sweet, Mental Health Services Director, Department of Mental Health

Members

Will Eberle, MPA, Executive Director, Recover Vermont, Vermont Association of Mental Health and Addiction Recovery

Vini Emery, (former) Program Manager: Recovery Coaches in the Emergency Department, Recovery Vermont

George Karabakakis, Chief Executive Officer, Health Care & Rehabilitation Services of Southeastern Vermont

Kate LaRose, Child, Adolescent and Family Unit, Department of Mental Health

Mary Kate Mohlman, Vermont Director of Public Policy, Bi-State Primary Care Association

Health Network

Andrew S. Pomerantz, MD

Former national director, integrated services, Office of mental health and suicide prevention, Veterans health administration, retired psychiatrist and primary care provider

Cynthia Seivwright, MA, LCMHC, Director, Substance Use Programs, Vermont Department of Health

Dan Towle, MBA, President and Founder Parker Advisors, LLC

Christine Werneke, Vice President of Business Development and Marketing, Home Health & Hospice, University of Vermont

Integration of Pediatric Care

Facilitators

Laurel Omland, Director, Child, Adolescent & Family Unit, Department of Mental Health

Dr. Haley McGowan, Children's Medical Director, Department of Mental Health

MEMBERS

Heather Bouchey, Deputy Secretary, Agency of Education

Dillon Burns, Mental Health Services Director, VT Care Partners

Mike Fisher, Office of the Health Care Advocate

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

Dr. Logan Hegg, UVMMC psychologist, pediatric integration

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

Ward Nial, Representative, National Alliance on Mental Health

Dr. Sara Pawlowski, UVMMC psychiatrist, pediatric integration

Dr. John Saroyan, Executive Director, Blueprint for Health

Connie Schutz, VT Department of Mental Health, CHILD grant (grant ended 9/30/2022)

Ilisa Stalberg, VDH Maternal Child Health

Sandi Yandow, Executive Director, Vermont Federation of Families for Children's Mental Health

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

Integration of Funding & Alignment of Performance Measures

Facilitators

Stephen DeVoe, Director of Quality & Accountability, Department of Mental Health

Ena Backus, Director of Health Care Reform, Agency of Human Services

Members

Sebastian Arduengo, Assistant General Counsel, Department of Financial Regulation

Susan Barrett, J.D., Executive Director, Green Mountain Care Board

Josiah Mueller, RN, BSN, MHS, Director of Value Based Care, OneCare Vermont

Michael Hartman, Chief Executive Officer, Lamoille County Mental Health Services

Bard Hill, Principal Assistant, Department of Disabilities, Aging, and Independent Living (now retired)

Lindsey Owen, Executive Director, Disability Rights Vermont

Geoffrey Pippenger, Director of Policy and Planning, Department for Children and Families

Julie Zack, Director, Integrated Health, Blue Cross Blue Shield Vermont

Integration of Workforce Development

Facilitators

Alison Krompf, Deputy Commissioner, Department of Mental Health

Kheya Ganguly, Director of Trauma Prevention and Resilience Development, Department of Mental Health

Members

Devon Green, Vice President of Government Relations, Vermont Association of Hospitals and Health Systems

Mary Kate Mohlman, Vermont Director of Public Policy, Bi-State Primary Care Association

Julie Tessler, Executive Director, Vermont Council of Developmental and Mental Health Services/Vermont Care Partners

Dan Towle, MBA, President and Founder Parker Advisors, LLC

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

Appendix #3

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

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

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

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

Appendix #4

Principles

1. **Equity**
    - Social Contributors to Health
2. **Patient choice/patient driven (vs. "patient centered")**
    - "Care where people live, work, and play"
    - Importance of mobile crisis services
    - Family/child/youth focus where appropriate
    - Lifespan approach
    - Wellness focus (not disease focused)
    - Peer specialists support
    - Care coordination (with coordination among the coordinators!) – need fair reimbursement, on-going training, workforce development ("they're swimming in a sea of vagueness.")
    - Do not medicalize mental health
    - Caregiver support/outreach for homebound
3. **Appropriate and Sustainable reimbursement, with ease of providing care regardless of insurance.**
    - Focus on collaboration and not focusing on competition/fighting for limited resources
    - Medicare issues –
        - Private mh providers can't bill. Yet we have one of the oldest populations in the country (needs are great).
        - Insufficient coverage overall, too complex.
4. **Robust IT**
    - Safety/security for IT/EHRs
    - IT Infrastructure/Health Information Exchange – patient no longer provides same info repeatedly
    - Data management – observe and measure clearly; equity issues
5. **Evidence-based/emerging practices**
    - Achieve quality without limiting innovation
    - Equity issues

Appendix #5

Inventory of Integrated Care Models

Model

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

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

Advantages

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

Challenges

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

care for family members

AIMS - Ambulatory Integration of the Medical and Social (different from the University of Washington model, below)

Focused on

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

Advantages

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

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

The University of Vermont Health Network is implanting this model.

This is a Collaborative Care Model (CoCM) developed at the University of Washington.

Five core principles define Collaborative Care and should inform every aspect of an implementation.

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

Advantages

The AIMS Center has extensive implementation resources, online guide, tools, and training to support integration.
Implementation Guide:
https://aims.uw.edu/sites/default/files/Step%20by%20Step%20CoCM%20Implementation%20Guide_110120.pdf

a free, downloadable appendix to the book that contains a thorough set of resources and guidance on implementing Collaborative Care.
http://aims.uw.edu/sites/default/files/Integrated%20Care%20Book_Appendix.pdf

Challenges

- Lacking all necessary service elements, particularly onsite PCP's, within a given organization
- May require community organization staff to carry multiple responsibilities
- May overburden part-time community organization staff

- May overburden social workers, care managers, and psychiatrist participants with care manager functions when added to existing responsibilities - need dedicated care manager, or share care management tasks among several staff (which has its own challenges)
- Requires infrastructure such as office space and protected time to meet with clients/patients
- Requires consistent buy-in and support from different levels within the organization
- Requires changes to existing organization structure and culture of care
- In one study, clinicians did not consistently use protocols within the collaborative care model, use screening tools, or update the team about patient status as care progressed.
- May challenge provider expectations about what is, or is not, within scope of care and clinical responsibility.
- Maintaining patient engagement

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

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

Advantages

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

Challenges

None identified

Blueprint for Health

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

Advantages

As of February 2022, there were 305,854 patients attributed to Blueprint practices. Of those,

- 285, 404 insurer-attributed patients
- 96,447 Medicaid-attributed patients
- 135 recognized Patient Centered Medical Homes
- 170 Core Community Health Team FTEs
- Includes Hub & Spoke, Women's Health Initiative, Community Health Teams
- Operates under the All-Payer model"

Appendix #6 – Workgroup Products

Integration of Primary Care Workgroup

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

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

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

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

One member of our group provided a presentation about peer specialists services. We had the Substance use and Prevention Division present on the use of recovery coaches in the community. General discussion focused on how increasing the number of people with lived

experience within health services would support providers while also helping to improve social contributors of health.

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

The major themes that have emerged for the workgroup are:

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

As a result, the Workgroup will pursue implementation of placing a community health worker in a single primary care practice as a single point of entry that is non-medical, equity-based and wellness-focused. Peer specialist supports will be explored further as well.

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

Certified Community Behavioral Health Clinics (CCBHCs)

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

- While CCBHCs improves access, they have had very little impact on overall health
- CCBHCs may further separate people with mental health needs from physical health care
- Existing value-based payment system DMH introduced in 2019 and the latest Global Commitment (Medicaid) waiver give Vermont ability to do everything CCBHCs do. Not clear that there is much to gain from CCBHC model.
- Designated mental health agencies have been doing interagency and multi-disciplinary work for years.

Peer Specialists Support

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

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

Trauma-Informed Services

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

Substance Use Services

- Recovery Coaches in the substance use world are certified
- Additional training required for specialty work (with pregnant/parenting moms, working in EDs)
- Required to have been in recovery themselves for certain period of time

- May be part-time
- Not in primary care settings currently
- Full-time unit of four employees at Division of Substance Use (VDH) supports Recovery Coaches
- Explore use of Recovery Coaches in primary care setting

Peer Specialists

- Should issue of peer specialists in primary care settings be the focus of this group? (Peer specialists are different than Community Health Workers)
- Need for clearly defined term – what do we mean by "Peer specialists?"
- Peer specialists as understood by this group (people with lived experience in mental health system of care, perhaps in substance use services) are critical and essential
- Also need to ensure peer specialists are part of a system of care where they are getting the support they need. Having a network, supervision, etc.
- Destigmatizing and addressing that mental health is a normal part of care.
- If focus on peer specialists, need to define role in medical settings (no knowledge in group of peer specialists in Primary Care currently)
    - Explore use of peer specialists on community health teams.
        - Could make more peer specialists available
        - May reduce stigma in these settings
- Draft Peer specialists job description
    - lived experience
    - understanding their role
    - how to onboard
    - self-care for peer specialists as position could be challenging, have their own network of supports
- Explore funding for Peer specialists supports – amount, source, etc.

Integration of Pediatric Care Workgroup

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

1. Children and youth undergo tremendous developmental change through the phases of early childhood, school-age, and older adolescence into young adulthood. This period of brain plasticity means that a child's development is impacted by their relationships with significant adults, especially within the family system, but also through experiences of their surrounding environment, which can range from healthy and growth-promoting to impairment-inducing.
2. Efforts to promote the healthy emotional and social development of children and their family members can have tremendous benefits for our communities in the long-term. These benefits include school readiness, academic success, choosing healthy behaviors, positive peer specialists/family relationships, and positive involvement in their community.
3. Integrated care incorporates wellness, prevention/promotion, resilience-development, trauma-responsive care, and early intervention across child and youth developmental stages and across all settings where children live, learn, play.
4. In any health care reform initiative, there needs to be intentional consideration of the unique needs of children, youth and families through an equity lens that recognizes the intersectionality of marginalized sub-populations including racial or ethnic groups, LGBTQ+, or those identified by socioeconomic status and the additional impacts such marginalization can have on access to healthcare.
5. Integrated care must consider the child's needs in the context of their family, school, and community and coordinate with those respective system partners. Such care must actively seek out the voices of youth, family members, and caregivers and recognize that families may have different pathways into mental health care.

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

Fundamental Building Blocks of Integrated Care

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

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

1. Mental Health Workforce - The mental health needs of children, youth, families, and adults will likely never be fully met by the professional workforce, even with the efforts to strengthen that workforce. A new public health approach founded on wellness, community, and equity is needed to address these issues. Everyone – children/youth, families, community members, providers, schools – has a role in supporting healthy development of children and families; some may need different resources and support to fulfill that role.

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

RECOMMENDATIONS

RESOURCES

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

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

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

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

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

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

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

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

CHANGE MANAGEMENT PROCESS

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

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

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

        i) conduct strengths-based system reviews of integration efforts

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

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

STRUCTURES, PATHWAYS AND TOOLS

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

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

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

7. Form a cross-sector Pediatric Measurement Team** to:

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

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

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

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

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

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

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

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

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

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

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

Integration of Funding & Alignment of Performance Measures

The Integration of Funding and Alignment of Performance Measures Workgroup has identified existing initiatives throughout Vermont that include performance measures and funding mechanisms for integration of mental health care into broader health care service delivery. As part of this work, Workgroup members have highlighted opportunities and challenges to the integration of funding and performance measures between physical and mental health. Further discussions and review of services covered by health insurance payers in Vermont and the existing performance measures on health outcomes have provided a roadmap for actionable next steps to ensure that mental health care continues to be integrated with physical health care services in a bi-directional manner.

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

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

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

- Green Mountain Care Board (GMCB)

  - GMCB provides publicly available reports and analyses, as well as a performance dashboard, that provides quantitative and qualitative information on Vermont's health care system using the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database.
    - Public Reports and Analyses | Green Mountain Care Board (vermont.gov)
    - Profile – state.of.vermont | Tableau Public
- Department of Vermont Health Access (DVHA)
  - DVHA's Quality Assurance and Performance Improvement Program measures health outcomes for Medicaid enrollee members, including experiences and satisfaction of care, quality of services provided, and cost efficiency.
    - DVHA tracks performance through standardized Healthcare Effectiveness Data and Information Set (HEDIS) measures via the Adult and Child Quality Measure Core Sets to standardize the measurement of healthcare quality across state Medicaid programs.
  - Vermont Child and Adult Core Sets
    - Child Core Set of Health Care Quality Measures for Vermont Medicaid - 2021 (clearimpact.com)
    - Adult Core Set of Health Care Quality Measures for Vermont Medicaid - 2021 (clearimpact.com)
  - OneCare Vermont
    - OneCare Vermont, the state's Accountable Care Organization, collaborates with health care providers and organizations annually to establish value-based care targets and provide financial incentives for those meeting or exceeding benchmarks.
    - Through this work, OneCare develops an annual quality work plan focusing on quality assurance activities, performance measurement, and performance improvement activities. As part of this oversight, OneCare provides publicly available data on shared interest quality measures focusing both on mental and physical health outcomes by the following payers:
      - Medicaid Next Generation: PowerPoint Presentation (onecarevt.org)
      - Medicare: PowerPoint Presentation (onecarevt.org)
      - Blue Cross Blue Shield of Vermont
        - Qualified Health Plan: PowerPoint Presentation (onecarevt.org)
        - Primary Population: PowerPoint Presentation (onecarevt.org)
      - MVP Qualified Health Plan: PowerPoint Presentation (onecarevt.org)
  - Vermont Program for Quality in Health Care (VPQHC)

- VPQHC facilitates reform efforts in health care throughout the state through application of quality improvement methodologies and stakeholder engagement to improve the health care experiences and outcomes for all Vermonters.
- This past year, VPQHC led a working group to design a framework of meaningful metrics that provides relevant information and accurately reflects the hospital system's quality of care within the state's healthcare reform environment.
    - This work involved significant stakeholder engagement from state government, health care provider organizations, and health insurance payers that resulted in a measure set inclusive of both mental and physical health metrics.
        - VT_Hospital_Quality_Framework_Report_2022.pdf (squarespace.com)

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

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

- Agency for Healthcare Research and Quality Academy Integrating Behavioral & Primary Care: Integrating Behavioral Health & Primary Care| AHRQ Academy

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

Integration of Workforce Development

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

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

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

- Six Core Strategies for reducing seclusion and restraint training
- Trauma Informed Systems Trauma Transformed
- Health equity
- Working with peer support specialists (certification process must be in place)

Shared or Leveraged Staffing

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

- **Expand what exists** and is working: VT Child Psychiatry Access Program

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

- **Formalize Collaborations** Using MOUs and shared policies for care coordination. Establish formal pathways to specialty care post screening and assessment
- **Examine** FQHC, DA and CCBHC opportunities for aligned goals and opportunities for shared or leveraged staffing through contracting.
    - Encourage healthcare practices to hire mental health staff through DA/SSA's. Complex mental health needs are better managed by staff who are connected to a strong mental health supervisory network and who are well connected to referral options for specialized services provided by DA/SSA's. Contracting through DA/SSA's supports integration and optimizes the state's limited work force.

- Define "specialty mental health care" appropriately and establish professional growth ladders to incentivize building experience and training in mental health specialty care.
    - Ensure specialty mental health care is reimbursed at parity with specialty medical care. Current mental health parity laws do not address disparity in specialty care services.
    - 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?
    - What incentives exist to support the professional growth of mental health providers to justify reimbursement parity to specialty care in healthcare?
    - Consider payment models that value mental health specialty care appropriately through increased reimbursement for use of evidence-based practices by highly trained providers.
    - Leverage national resources to establish a more robust clinical supervision network, using virtual options to develop better access to specialized clinical supervision.
- Explore how care may be "best served" at a DA, CCBHC or an FQHC.
    - Is serving adults with Serious Mental Illness and children and youth with Serious Emotional Disturbance equal to "specialty care" in healthcare? Specialty mental health care is neither well defined or equitably funded. Current parity laws do not include mental health specialty care.
    - Develop workforce to best meet primary care, care coordination and specialty care needs.
    - Develop recommendations for training specialists
    - Develop recommendations for compensating for that specialty.

- Develop guiding principles for Workforce Development
    - identify current successful examples
        - Suicide Safe Pathways to Care mini grant project. Public/private partnership between Dept of Mental Health and the Center for Health and Learning offered small grant opportunities for

participation in a six-month action-oriented effort. Leveraging existing Blueprint resources for coordination, 17 primary care practices signed up to partner with their local designated mental health agency to develop a protocol for how identification, triage and referral of suicidal individuals would be well managed in their regions. Primary Care engaged in specific training on how to talk with patients experiencing suicidality about access to lethal means and provided data on the type of screenings they provide to assist with identification. Goal to increase use and fidelity to evidence-based practices of screening, referral and follow up, build relationships between primary care and mental health, and develop a shared understanding of how someone in suicidal crisis can be best served leveraging integrated resources.

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

Equity

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

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

These recommendations align with or repeat those of the HEAC.

- Recruitment
    - Update and expand definitions of professions
        - Specify which professions are “healthcare system workers.” Does this term include, for example
            - Mental health clinicians
            - Peer specialists
            - Recovery coaches
    - Dismantle barriers to entry
        - Academic, financial, and regulatory inequities make it harder for people from marginalized communities to enter healthcare professions[2].
        - Licensing
            - Exams for all licensed professions for must require more knowledge and understanding about health equity, inclusion, and accessibility
            - Leverage Act 107, 2022 (An act relating to telehealth licensure and registration) and to provisional licensure for professions regulated by the Office of Professional Regulation) to create a Health Equity Telehealth Program specifically to provide access to a broader selection of providers who possess the cultural competency and humility required to provide the appropriate care to marginalized communities
            - Formally request a review by the Office of Professional Regulation of the relevant inter-state licensure requirements to ensure that out-of-state telehealth providers are held to the same standards of health equity training as Vermont-based providers
            - Ensure that peer specialists support providers are trained in health equity
        - Pay for prospective workers’ travel and moving expenses
        - Provide onboarding and educational materials in more languages
        - Consider specifically how professionals can serve in under-saturated practice areas, such as group support in mental health services and among rural populations
- Existing community support groups
    - Create grant opportunities overseen by the HEAC to provide

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

services to marginalized populations

- Create a model of reimbursement or insurance coverage requirements for alternative therapies such as reiki, herbalism, Chinese medicine and other nonwestern approaches.

Health Equity Advisory Council (HEAC) Training recommendations

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

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

Ongoing Training and Education

- “Create standardized baseline awareness training on origins, impact and mitigation approaches to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism. (HEAC, in consultation with leaders from impacted communities and equity industry associations).
- Create a statewide mandate to ensure equity training and education is amongst the highest of priorities and essential for professional development. Communicate the urgency and priority of education against homophobia/transphobia, ableism, and systemic racism alongside existing trainings that are already heavily weighted, such as Equal Opportunity gender-related anti-bias trainings and sexual harassment prevention trainings.
- Ensure that all employees understand their role in furthering systemic change.
- Training and education should be role-based and created in conjunction with impacted community leaders and equity professional associations.
- Legislation is needed that requires equity training for billing staff, paramedics, receptionists, schedulers, social workers, peer specialists supports and anyone else who plays a significant role in patient experiences or outcomes.

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

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

[i] Druss BG, Rohrbaugh RM, Levinson CM, Rosenheck RA. Integrated Medical Care for Patients With Serious Psychiatric Illness: A Randomized Trial. Arch Gen Psychiatry. 2001;58(9):861–868. doi:10.1001/archpsyc.58.9.861

[ii] Miller-Matero LR, Khan S, Thiem R, DeHondt T, Dubaybo H, Moore D. Integrated primary care: patient perceptions and the role of mental health stigma. Prim Health Care

Res Dev. 2018 Jun 19;20:e48. doi: 10.1017/S1463423618000403. PMID: 29914587; PMCID: PMC6567893.

[iii] Phelan SM, Salinas M, Pankey T, Cummings G, Allen JP, Waniger A, Miller NE, Lebow J, Dovidio JF, van Ryn M, Doubeni CA. Patient and Health Care Professional Perspectives on Stigma in Integrated Behavioral Health: Barriers and Recommendations. Ann Fam Med. 2023 Feb;21(Suppl 2):S56-S60. doi: 10.1370/afm.2924. PMID: 36849477; PMCID: PMC9970680.

[iv] Why We Need Mental Health Care Integration, National Alliance on Mental Illness, March 2, 2022 https://www.nami.org/Blogs/NAMI-Blog/March-2022/Why-We-Need-Mental-Health-Care-Integration

[v] Singer, SJ, Sinaiko, AD, Tietschert, MV, et al. Care integration within and outside health system boundaries. *Health Serv Res*. 2020; 55: 1033–1048. https://doi.org/10.1111/1475-6773.13578

[vi] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September, 1978. www.who.int/hpr/NPH/docs/declaration_almaata.pdf(accessed 15 February 2008) [PubMed] [Google Scholar]

[vii] Benjamin G. Druss, M.D., M.P.H., Manasvini Singh, M.S.P.H., Silke A. von Esenwein, Ph.D., Gretl E. Glick, M.P.H.,

Stephanie Tapscott, M.S.W., Sherry Jenkins Tucker, M.A., Cathy A. Lally, M.S.P.H., Evelina W. Sterling, Ph.D. Psychiatric Services in Advance (doi: 10.1176/appi.ps.201700352)

[viii] Benjamin G. Druss, M.D., M.P.H., Howard H. Goldman, M.D., Ph.D. Integrating Health and Mental Health Services: A Past and Future History; American Journal of Psychiatry (doi.org/10.1176/appi.ajp.2018.18020169)