Workgroup Name:	Workgroup Leader:
Vermont Blueprint for Health Workgroup for Program Designs for Community Health Teams for Expansion of Community Health Teams	Julie Parker
	Mtg. Facilitator: Julie Parker **Mtg. Recorder:** Averiel Hossley **Where**: Virtual Meeting
	Conference Room: none
	Date: 4-13-23 **Time:** 9:00-10:00 am

Attendees			
Name	Affiliation	Name	Affiliation
Jessa Barnard	Vermont Medical Society	Anje Van Berckelaer	Battenkill Valley Health Center FQHC
Gretchen Pembroke	Designated Agency/ Clara Martin Center	Devon Green	VAHHS
Merideth Drude	Blueprint Program Manager	Samantha Sweet	DMH
Ellen Talbert	Blueprint QI	Andrea Nicoletta	VDH- CHW Lead
Sarah McLain	Blueprint QI	Megan Mitchell	VDH- DSUP
Bryan Leroux	Dartmouth	Teri Closterman	Consumer
Carey Yeaton	CHT Lead Lamoille	Kathleen Hentcy	Dept of Mental Health
Katja Evans	Program Manager for Blueprint for Health	Lindsey Lozoskie	NCQA
Laura Pentenrieder	DULCE	Ilisa Stalberg	DULCE

Non-Workgroup Members			
Dr. John Saroyan	Executive Director, Blueprint for Health	**Mara Donohue**	Assistant Director Blueprint for Health
Caleb Denton	Data Analytics and Info Administrator Blueprint for Health	**Jenn Herwood**	Payment Operations Administrator Blueprint for Health

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Averiel Hossley	Administrative Assistant Blueprint for Health	**Erin Just**	Quality Improvement Facilitator Coordinator

	Agenda Topic	Topic Facilitator	NOTES (*notes are provided in italics and blue*)	Action Items
I				
II		Julie Parker	*Slides given will be linked under Action Items. Minutes for all groups are available on the Blueprint for Health webpage.* *Starting off with an abridged version of a "101" on the Blueprint. [Slide 3]* *Community Health team dollars are branched out to a variety of care sources. [Slide 4]* *The community as a whole plays a large role in keeping our population healthy. [Slide 5]* *A current breakdown of CHT distribution is given in the form of a pie chart. There are check-ins with all practices to assess needs. [Slide 6]* *A breakdown of the current aims for the CHT expansion plan. [Slide 7]* *Key Areas of the proposal [Slide 8]* *Screening is the main focus. We want to ensure Screening is implemented properly. [Slide 9]* *Social Determinants of Health definition and elaboration. [Slide 10]* *About screeners – are they meant to be applied within a specific practice or just within where the CHTs are engaged?* *That's usually how the CHTs are reached. Within those*	https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/Program%20Design%20Workgroup%202_0.pdf Presentation given by Julie Parker. Please reference the slide numbers listed in the minutes.

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			screenings, that would be a moment to consider connecting with the CHT *Carey: Screening is done with everybody by our CHT. It's connected to specific visit types as well. It does identify people that we wouldn't otherwise consider needing support.* *We know that part of this workgroup is working in tandem with the DULCE expansion and integration group. There are set visits with DULCE, it is very systemized. When we talk about new episodes of care, I want to spend time talking about what we know is happening for parents in pediatric organizations. There are Bright Futures questions and others related to mental health, and we would love to know if parent/caregiver who are attending how much they are screened. We know that in some cases parents are more consistent in bringing to care then getting their own care.* *Do we know if that is happening in pediatrics/family practices? If we took a more active approach to screening in pediatrics to reach parents.* *It's not so much the screening, but what to do with that information and how to connect with resources.* *If we expand screening, let's be sure where it's going and we have a place to direct patients.* *And if a CHT is on site then you can do warm handoffs, but if you don't have resources there is hesitancy in screening.* *The VCHIP did a QI program around family wellbeing around whole-family health, screening parental depression and tracking what has been happening with those screenings* *That would be a great resource. As we look at expanding services, do we want to think about how we are screening in those pediatric practices as an opportunity to support parents in getting connected to resources or a hand off to their own primary care office.* *"NCQA PCMH standards do also include assessment of SDoH needs- which would be filled out by the parent and can be used to identify needs and connect individuals to services in the community. (Standards KM 02, KM 07)"* *What we are finding is the Bright Future screenings are*	

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			being done, but not others around mental health and others. We would need to be aware of systems in place and where gaps exist. Around SDOHs. *Back into the Slides, addressing SDOHs [Slide 11]* *PCMH – Adults. Proposed requirements. [Slide 12]* *For our next meeting, reviewing screenings more. Asking participants to do screenings with them, discussing the frequency and effectiveness, as well as missing questions that could be helpful.* *The state has been awarded a planning grant to become a Certified Behavioral Health Specialist State, there are other designated agencies interested, and we are the first in Vermont. Quality health indicators, measuring and tracking requirements, identifying a path of referral for access to primary care.* *In the following sessions that will be an important talking point.* *It would be helpful to understand the FQHCs core questions and other sources to share those questions as well. Discussion to address how those screenings go, and a further questions around what happens then. Then the best referral pathways to follow for them.* *One practices focus primarily on food insecurity, as we have resources to allocate to that, (food shelf and other help) as it is our main immediate help. Giving practices the ability to narrow their focus would give them proper motivation to act, in lieu of asking for too much and arriving at paralysis for areas they are unable to help in.* *Specifying directions for help for individual practices. Narrowing down to a main focus in each community, who has what resources.* *"There is also some research to suggest that if you screen for food security that can be a proxy for other SDOH"* *"Here is the Hunger Vital Sign which many early childhood partners and peds utilize: https://childrenshealthwatch.org/public-policy/hunger-vital-sign/ "* *In terms of role clarification; case managers vs CHWs and what roles they play.*	

			Template or process for having these conversations? It would be helpful to have an internal screening to set strategy.	
III				
IV				
V				

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