LIT Extravaganza 2024

Breakout Session C: Interagency Agreement Updates

Facilitators: *Alicia Hanrahan, AOE and Laurel Omland, DMH*

Notetaker: *Karen Price*

1. **Interagency Agreement (IA) observation**
    - Agreement has not been updated since 2005
    - Some department names need to be updated--Cheryle Wilcox has corrected these technicalities
    - There are differences between requirements of leaders of AOE/AHS in this document.
    - If a general education youth has a Section 504 plan, there is no special education determination.
    - CSP is being practiced more broadly than it is in the written agreement.
    - General education youth are going to residential - a quarter of kids getting residential who do not have a special education disability diagnosis.
        i. We could look at the CRC data on Spec Education status to better understand this
    - It should be updated every 5 years to take into account new trends
        i. E.g. trends of 2005 vs trends of 2024)
        ii. There is an increased incidence of diagnosis of autism
    - Should the IA be updated to reflect current issues? There are now many more children and youth with medical complications. That seems to be a change.
    - Is there a deadline for the IA update?
        i. SIT hopes to have it by the 20th anniversary of the IA -i.e. sometime next year.

2. **Funding components**
    - IA should state that the AOE should be as responsible as AHS for funding parent reps.
    - IA is where we went from SED to all education disabilities, and that is an important piece to ensure funding across all AHS departments on SIT and AOE.
    - Funding in IA talks about state-placed children. There could be a section for parent rep funding there.
    - State-placed students are not necessarily through CSP.
    - Other funding obligations: talks about FAPE.
    - There is a cost associated with the Act 264 process that hasn't been funded in years. It is an unfunded law. There is some funding for high end supports but no funding for day-to-day structure for the CSP process.
    - Could some of these costs be built into the Certified Community-Based integrated Health Center (CCBHC) Cost based approach? The state got a planning grant to work towards state certification of CCBHCs - multiyear initiative. CCBHC - VT's renamed version of the federal CCBHC (Certified Community Behavioral Health Clinic) -this should be built into or accommodated in some way in the IA.

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3. **Dispute resolution section**
    - We want to be clear that dispute resolution about residential placement goes through the CRC and then the agencies responsible for funding. SIT is not responsible for those disputes. SIT handles other areas of dispute resolution.
    - IA could improve language on the dispute resolution section.
    - Cases go from LIT to SIT for brainstorming.
    - When there are disputes at local level, it goes to SIT, SIT writes letter and then sends it out.
        - Have disputes gone up to the Commissioner/Sec level?
        - There are two situations that haven't been resolved and have been in the media.

4. **Residential Placements**
    - When is the responsibility of residential placements under special ed and then when does it bump to Medicaid? Is it clear? Do we need language to clarify?
    - There is a big portion in the IA about transition. (VR = HIreAbility.) Take a look at those parts about transition and post-secondary goals in the IEPs. Is it all necessary?
        i. Background: There was a large number of transition aged youth in 2005.
    - There is a lack of education alternative placements

5. **The importance of team-based care has increased.**
    - There have been more meetings which have become more confusing over the years.
    - Physical health care wants to be at the table.
        i. They have no formal role in the IA. CSHN sees themselves as the lead.
    - The words "Primary care" is not in the IA. Need to weave it in. Where to put that in? They should be at least be given the option to attend. CSHN is a state agency. Should they be included? Who should be named as part of primary care. Who takes the lead if the child's prime disability is a physical health diagnosis? Who takes the lead in a meeting?
    - CSHN no longer has case managers. CSPs have been using pediatric PCP managers/social workers
    - Almost half of CSPs attended in the last couple of years, there have been medical representatives. Medical reps are not as present at LITs.
    - AHS and field services offices have a contract to look at team based care - inclusive but also beyond CSP.
    - Other initiatives (e.g. Blue Print) have a focus on team based care.

- Cheryle Wilcox is bringing the voice of Act 264 to this discussion. We don't want duplication of teams/effort.
- Should there be a reference to AHS team based care in in the IA? Is AOE at the table for this discussion?

6. **Identification of lead on meeting**
   - There is language in the IA that it be the entity that has the relationship with the family, not necessarily the payor of services.
   - The lead has to fill out the form to do the process if the child needs a higher level of care.
   - There should be a delegation of tasks within the team in case tasks need to be done by others who have more expertise.
   - There is a disconnect between the spirit of the law and how it plays out in practice. It is being used as a means to an end. It sometimes posed as a demand on parents, rather than as a support e.g. truism. In many school districts, parents are told "You must have a CSP if your child is absent etc." CSPs are being used even when that is not the correct path.

7. **Getting the message about Act 264 Out to Families**
   - There needs to be a state leadership role to get the message out there and that message should be available all the time.
   - There is a shortage of resources for the state to educate the local teams in an intensive manner.
   - How should information be shared? PSAs? Recorded webinars? What is needed for more trainings to happen in the regions?
   - Is there a Summit on all these team meetings – i.e. should there be coordination of the coordinating teams?

8. Data

- There should something in the IA about data. There is a need for coordination for data collection.
- There is a data sharing MOU between AOE and DCF, but it doesn't cover CSPs.
- Within the IA in the quarterly review paragraph which talks about data. There needs to be more clarification about data in the IA- what are we collecting? Is this quarterly review actually happening in practice? Should the meetings be quarterly, or should the frequency be reduced? If it is agreed upon, then it should happen. Quarterly reviews might be excessive. Should they be counted as CSPs? Team meetings? Confusion causes differences in interpretation. We should all use the same definitions for what a follow-up CSP meeting is.
- Act 264 Board has discussed the data and using EHRs with a data entry point.
- MH agencies are a required CSP member and have electronic data capability.
- Look at demographics - Who is getting CSP meetings and who is not?
- Electronic Health Records – this is a big shift at Designated Agencies with collecting data
- CSP follow-ups vs team treatment - went over different MH agencies and how they differentiate internally. There's a lot of paperwork to be keeping track of. There is a paperwork burden on the MH agencies.
- There is some resistance from DAs towards schools to holding CSPs - can we just call it a team meeting? Not feeling this is systemized.
- Where should state systemize, vs leaving it for the local level?