

Meeting Minutes—ACT 264/Joint Meeting

10.28.2016

ATTENDING: Jessica Bernard, Betsy Cain, Alice Maynard, Matt Wolf, Cinn Smith, Kathy Holsopple, Doug Norford, Tiffany Hubbard John Pierce.
Kristin Holsman-Francoeur joined via phone.

Agenda Items	Discussion Points	Decisions/Actions
Joint ACT264 & SPSC Meeting (10:05-12:30)		
❖ Review/Approve Minutes	<ul style="list-style-type: none"> September minutes were approved. 	<ul style="list-style-type: none"> October minutes will be sent by Jessica/Linda.
❖ DMH Commissioner’s Update—Deputy Commissioner Melissa Bailey (DMH)	<ul style="list-style-type: none"> Melissa Bailey, Deputy Commissioner, would like to attend these meetings once every quarter, if possible. Working with Agency of Education (AOE) to reinvigorate Act 264 and the Transformation Transfer Initiative (TTI). The Act 46 report, around AOE and AHS working together, shows that resources have dwindled and we need to reinvigorate the initiatives. Started with 3 school districts with kids who had many concerns or kids with SED/IDD, where we know families are struggling and poverty is a factor: Winooski, Orleans South, and the Barre. They talked to schools and DAs to identify the key issues. Worried that the opiate crisis is an underlying factor and younger and younger kids are dysregulated and increasingly violent. Staff and families are feeling overwhelmed and unable to meet needs because home life is so unsafe or unstructured. Trauma is everyone’s responsibility, and we need to work together to shift what is happening. It is a community’s responsibility, while agencies have a big role. Reinvigorating Act 264 could help rebuild the foundation of our system of care. We are applying for a 6-month TTI grant with VT Federation of Families for Children’s Mental Health (VFFCMH) (if we get it), which aims to bring together developmental services, family services, and DMH to talk about differences that are leading to gaps, get to a place where we can have a common understanding, and reinforce SIT/LIT. It would also fund training initiatives. FYI: There is a Building Flourishing Communities Summit, Dec. 1 & 2 (Lake Morey Inn, Fairlee, VT), so attend if you can. EDs/Brattleboro Retreat (BR) and hospital diversion—41 adults presented at EDs this week, the majority being unknown to DAs. EDs are overwhelmed and worried to discharge if they are not safe to themselves and others. BR is full, beds are down to 18 on adolescent floors. Having a hard time getting kids into residential programs, therapeutic foster care, and finding community resources. Trying to get a hospital diversion program going in Southern VT, we’re hopeful, but nothing official yet. It appears that hospitals are trying to get plans in place to build residential and hospital beds. DMH wants the future to rely not on residential/hospital beds, but to build up community agencies and resources. Healthcare reform/Medicare Pathways—We’ve signed an all-payer waiver with the Feds. Not sure what it means, fully. We’re still trying to get things off the ground and plan for new funding. We’ve also put in requests for funding Zero Suicide and evidence-based practices, statewide. VFFCMH is leading trainings for ACEs, with the help of Matt. It is a strength- 	

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	<p>based approach to promoting resiliency. The Building Flourishing Communities Summit will also look at this resiliency version on ACEs. They are still looking for people to facilitate some conversations. Get in touch with Kathy Hentcy if you are interested. Turn “us” vs. “them” around. We all have lived experience to some degree. Let’s respect everyone’s experience. John asked about what the reform will look like. Melissa responded that we’re not sure yet. How will we operationalize quality of care? There is a lot of work that still needs to be done, but there may be funding opportunities to spend money in the right places (not a new infusion), but we don’t know yet. A move toward having care that focuses on a mind-body approach could help people feel better, emotionally and physically. Melissa gave an example of her own mother-in-law’s back pain and the doctor’s inability to treat the complex emotions, simultaneously, with the pain. It’s a process to get insurance to understand what helps people get better. The medical world has a very different perspective than mental health. It will be interesting to see how we can work together.</p> <ul style="list-style-type: none"> • Medicaid Pathways—Working at service delivery and payment reform, very aligned with the work we’ve done with IFS, but it’s on a much larger scale. The all-payer waiver negotiations insisted that DMH and SA combine resources, but we felt it wasn’t funded properly and wouldn’t deliver as promised. Over the next 4 years, we will be developing the system to deliver quality over quantity of services. We have decent alignment in some areas, especially where IFS has been. Others need time to focus and catch up. We’re figuring out how to roll everything out. There will be changes, but we don’t know what that will look like. Melissa will send alignment report. 	
<ul style="list-style-type: none"> ❖ Update on the HCBS Alignment Report— Emma Harrigan and Laurel Omland (DMH) 	<ul style="list-style-type: none"> • Update to the HCBS Rule Changes: How does EFT Waiver align? The rules apply to all former waivers (TBI, DS, CMH, Choices for Care, CRT, etc...). We have a timeline with the Feds to do the assessment, plan remediation, get public input, and adjust as needed. Laurel has been discussing children’s mental health. The timeline is broad and breaks down all the waivers and includes the necessary tasks. The assessment has been completed and we are working on developing the work plan. DS is a bit ahead. Based on input from Children’s Directors, they noticed a section around therapeutic foster care and transitional living that stated the contract is for only 1 child. Laurel has communicated that there are often more children in these settings and the language will need to be changed. Some of the language is focused on adult care and does not take the needs of children and families into the requirements. In the alignment report, DMH noted where things are N/A or need to be altered. Also, DMH asked for Technical Assistance. Next steps are to determine how the standards are applied to children. That’s been done, so just waiting for CMS’s response. The drafted remediation was being reviewed at this meeting, then it will be posted on the DMH website for 30 days, starting Dec 1st for public comment. One area that is being looked at: Do DAs have conflict of interest because they create the plan of care with clients which often refer them to their own agency for services? That’s being explored further. Example: a person writing the service plan can’t be a relative or have a financial interest over the 	

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	<p>client’s money. Also, regarding conflict-free case management, a case manager can’t provide services and write plan. Our small state and DA system makes this almost impossible to avoid. The hope is DMH (Central Office) will lead the discussion that involves the remediation to this plan. This conflict can’t be eliminated, but the hope is DMH might suggest coming up with rules and protections that ensure clients have a way to address concerns. DMH plans to update the Enhanced Family Treatment manual, minimum standards, and develop a plan for site-specific assessments. DMH will be working on language and will publish the final version for public comment. A board member suggested families would benefit from clear definitions and expectations about what each role does at an agency, since it’s not always clear who is the point of contact or who would provide which service. The term “conflict-free case management” means there is no issue about the agency or employee benefitting from the plan being created and that the family has a choice where they receive services in the community. If protections are in place, the hope is progress can happen without big changes to system. VT does not have skills workers outside of the DA system who accept Medicare. Board questioned if the home provider has guardianship and creates the service plan, isn’t that a conflict? Applies more to DS care homes, but this is a very important issue to highlight. Are there ombudsmen who could help provide oversight? Not that DMH was aware of for DAs. Are families being given all the information about what services they must receive at the DA due to the waiver requirements and what they can seek outside of the agency? If not, this needs to be encouraged/required. If sites can’t come into compliance, it is possible residents would need to be relocated. DMH doesn’t anticipate this happening, but it needs to be prepared and have a relocation plan. It will know more in the future. A member asked if CRC tracks data and if she could have a recent report. Laurel is currently looking at what they can pull and send to LITs about residential placements. The report Cheryle sent last month was a direct result of Laurel/CRC’s work.</p>	
<p>❖ IFS Update— Cheryle Bilodeau (IFS)</p>	<ul style="list-style-type: none"> • Cheryle passed out SIT’s table of contents for their System of Care (SOC) plan. There is a lot of data and they need to decide how and what to use. This should be out by December and ready for the new Administration. Alice pointed out typos. Some elements are from statute and are clunky, but it can’t be modified. With over 1,300 kids being served in residential, it is increasing and we are part of a nationwide trend, probably heavily correlated with opiate epidemic. Lauren Kasehagen, Senior MCH Epidemiologist, is looking at a lot of the pressure points and challenges. Alice suggested we add values to the document and, under addendums, add Act 264 and consider CSP. Acknowledging this was a great suggestion, Cheryle said IFS references statutory and that point in opening but not the values. Alice would like to see a list of LITs which have parent reps and those that do not. Should this Board send letters to those that do not and ask how they are recruiting them? • LIT Extravaganza is Tuesday! About 80 people are coming. IFS has worked hard to get partners from all over the state. There will be breakout sessions in the afternoon. 	

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	<ul style="list-style-type: none"> IFS is still struggling to help people understand that they are not able to solve all issues or be the fix for everything. They are looking at data and how funding can be used to meet the needs that they are able to address. IFS is still mostly tied to mental-health dollars. Cheryle was asked if Addison County is serving more kids with DD/DS, why can't they contribute more. She said that is the conversation that IFS is having right now. In Nov., Cheryle is helping with the Burlington case review, which is very time consuming. She hopes to be done so she can attend our Nov. meeting, but we can have Carol come in Cheryle's place if the review isn't finished. Turn the Curve Update—IFS has done interviews for the director position but is waiting on election outcome and appointments before bringing anyone new on. IFS is holding its collective breath and working hard, regardless of possible changes, but it's stressful. There are many people not in appointed positions who will keep the momentum going. 	
❖ Public Comment	<ul style="list-style-type: none"> None. 	
	Break 12:30-12:45	
	SPSC Meeting 12:45-2:00	
❖ MHBG Invitation and Update—Judy Rosenstreich (DMH)	<ul style="list-style-type: none"> Judy is the Senior Policy Advisor at DMH. While there are insufficient resources for the needs of mental health, VT is ahead of most other states in terms of what it does and tries to offer. VT established State Program Standing Committees (SPSC) many years ago and it isn't duplicated across the country. The Mental Health Block Grant (MHBG) was transitioned to Judy in the past year or so. The MHBG is a non-competitive grant enacted by Congress and is assured, but we must meet certain requirements, set by SAMHSA. This grant provides about one-million dollars in funding, to both adults and children. The people on the Standing Committee currently have a lot of expertise, and we want to continue that. The MHBG Council is a separate entity, responsible for overseeing money spent, monitoring services, engaging in advocacy, and making recommendations, very similar to SPSC. The MHBG Council, as a whole, lacks the experience that this group has. In the past, the MHBG Council only met a few times per year. Positions are appointed by Secretary of Human Services. When secretaries change, the group needs to be reconstituted. DMH will need to wait for the election to know if there will be a change in leadership and if they will make changes to the current MHBG Council. DMH would like to coordinate the SPSC group with the MHBG Council. The group meets more often now and is trying to define their role and make sure they are relevant and influential. DMH Commissioner Frank Reed would like these two groups to collaborate more. SAMHSA will provide technical assistance to the planning council, to help define roles, get assistance around advocacy, recruit members, and advise on structure. DMH hopes this will lead to better organization and more structured and effective meetings. The goal is to empower the people on the Council to help lead this group in the future. In the past, all members of the SPSC were automatically members of MHBG Council (with official appointment). However, attendance was rare, 	<p>Send SPSC MHBG notes. Send Judy SPSC names and emails.</p>

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	<p>despite being members. Judy has worked hard to reconstitute the group and looked at membership to make sure AHS wasn't the only perspective being represented regarding the different issues while making sure this is a meaningful process. We can't have more than 50% of the members be State or be providers. It's been challenging to attract more members with lived experience or from the community. Judy is here to let everyone know that they are invited to participate in the MHBG Council, that we need your perspective, even if it's by phone. We will share minutes between our groups, going forward, to keep everyone in the loop. This year, DMH did receive new money and used the Council to help influence where it would be spent. The TA will involve Council organization, how it can partner with the SPSC, and how we fulfill the roles of the Council. Going forward, SPSC and MHBG will be getting updates about each other's meetings. MHBG will meet in the summer to prepare for a Sept. deadline, to reapply for the grant, which happens every other year. It meets again before Dec 1st to address annual report, as well as meets after elections to talk about advocacy and leadership change. On average, they meet 5 times a year in Waterbury. Participants get a stipend and mileage reimbursement, if not getting paid for their time by employer. Kathy asked why phone participation is paid less than in person? The group felt \$10 was not enough to get participation. Judy responded that she will take the feedback to the Commissioner. The next meeting is Nov 17th. The funding history involves the pool of money having declined over the years, with the formula used by the Feds not allotting much to VT, due to its population size. SAMHSA came for their audit this summer (happens every 5 years). It's a lot of work for a small amount of money, but it's worth it to receive \$400,000 for respite. This year we did get an extra amount of money, which we conferred with the MHBG Council over, and the Commissioner did go with their recommendation. Regarding SAMHSA wanting SA and MH to combine their MHBG funds, we have pushed back.</p>	
<ul style="list-style-type: none"> ❖ Agenda Items for Nov Meeting on 11/18? 	<ul style="list-style-type: none"> ❖ Charlie attend? Act 264 group does not feel they should take notes, how do we get other AHS agencies involved? Dec. (after election?) ❖ CSP process-Kris ❖ Recovery and Resiliency grant? Kathy (Dec.?) ❖ SIT/LIT questions finalized ❖ Designation NFI 	
<ul style="list-style-type: none"> ❖ 		