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2/14/2022
Adult State Program Standing Committee Minutes **DRAFT**
Present
Members: ☒Bert Dyer (he/him) ☒ Malaika Puffer (she/her) ☒ Ward Nial (he/him) ☐Kate Hunt (she/her) (ex)
☒ Marla Simpson (she/they) ☒Dan Towle (he/him) ☒Lynne Cardozo (she/her) ☒Zach Hughes (he/him)
☒Christopher Rotsettis (he/him) ☒Ann C Cummins (she/her) ☐Erin Nichols (they/she) (ex) ☒Michael McAdoo
DMH/State Staff: ☒Eva Dayon (they/them) ☒Nicole DiStasio (they/she) ☐Steve DeVoe ☐Dylan Frazer ☐Brian Smith ☐Nick Nichols
☒Dr. Trish Singer (she/her) ☒Katie Smith
Public: ☐Steve Walsh ☒Joanna Cole ☐Rachel Hobart ☐Alexis McGuiness ☐Elaine Ball ☐Dillon Burns ☒Brett Yates

Agenda
12:30 SPSC Business:
- Standing items: introductions, review agenda, announcements, vote on January minutes and public comment
- New items: LPSCs- discuss august public comment, update on older Vermonters working group, On having an AMH SPSC annual report

2:00 Request for Proposal Structure Feedback: On improving person-centered services in Home ad Community Based Services by Dylan Frazer
2:30 DMH Leadership Update: (15 min) Nick Nichols, Suicide Prevention Update (15 min) Brian Smith, Housing Update
3:00 Public comment
3:10 March draft agenda
3:30 Adjourn

Agenda Item	**Discussion** (follow up items in yellow) **Facilitator: Marla** **Timekeeper: n/a**
Opening and AMH SPSC Business	**Motion** to allow public comments throughout meeting. Made by Dan. Seconded by Zach. All in favor. Passes. **Motion** to accept January minutes as presented. Made by Lynne, Dan seconds. All in favor, with one abstention. Request to have follow up regarding this item from December minutes: Are you reconsidering the **Application requirements for the EIP committee**? Steve will follow up. Specific issue discussed by members included- peers (and only peers) are required to divulge tax returns. Response: Steve DeVoe (DMH Director of Quality and Accountability) is finalizing the update with other members of the Senior Leadership Team and we will notify the committee with an update as soon as possible. Update on **Older Vermonters Working Group**: Briefly discussed the initial draft being almost complete from this working group's recommendation. Goal to have final draft by June 2022. Subgroup is currently not making recommendations for changes on the current definition of self-neglect. This committee's representative expressed the importance of self-

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	determination. Adult Protective Services takes responsibility for self-neglect in some states- Vermont is considering that. Members shared personal caretaking experiences. Public: Respectful language is critical to this work. Discussed August public comment regarding the **structure of Local Program Standing Committees** (LPSCs). Program people from agencies are interested in discussing the expectations for LPSCs. The Administrative Rules govern this structure, making it a complex process to change quickly, but this should no be a barrier to discussing what an ideal way would be to gather feedback from individual with lived experience. Members are open to discussing what alternatives to this structure could be. The State Program Standing Committee has done intentional reach out to Local committees in the last two years. The State committee notices the wide variation in participation/membership/content at Local committees. Request for Vermont Care Partners to share any notes about DA/SSA network thoughts on benefits/challenges/alternatives. Stipends for time on Local committees would help in recruitment/retention. Town hall/forum models allow for more diverse membership-especially those having short-term experiences with care. Could open any public to attend these types of forums. Would like to have virtual/video platform meetings available. Try to identify all stakeholders you would want present – how to engage those groups specifically. Utilizing front porch forum or other social media to gather feedback from local voice. Is there interest in subgroup between AMH and CYFS State Standing Committees, Vermont Care Partners to discuss this (Malaika, Marla, Ward). Members expressed concern about the Rules not being reviewed/updated on a regular schedule. Potential **AMH SPSC Annual Report**- concern from members about amount of work involved in this. Not envisioning a summary of minutes- more a consensus of recommendations for the mental health system of care. For example, would like clarity on access to advocates in inpatient settings during the pandemic. Could identify themes in concerns among designated agencies. One-to-two-page deliverable document. Flag recommendations made by the committee, which were acted upon. SAMHSA Block Grant Planning Council is engaging a consultant to support the council. This committee could be interested in getting this kind of technical assistance in a short-term basis. Goal target audience is the governor since that is who appoints committee members. Potential Report Outline • Statements of Recommendations • Finding and concerns seen this past year • Open Actions or responses to questions from DMH
Request for Proposal Structure Feedback	On Improving person-centered services in HCBS (Community Rehabilitation and Treatment) programs led by Dylan Frazer, Deputy Director of Medicaid Policy • Presentation shared- see attachment A. Feedback welcome during or after this meeting. • DVHA HCBS Conflict of Interest Plan • COI= Conflict of Interest

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	• HCBS= Home and Community Based Services—services that are not in an institutional facility like hospital. For DMH programs, that includes Community Rehabilitation and Treatment for Adults and Intensive Home and Community Based Services for youth. • Who gets to define what is a conflict of interest? Who determines if the conflict is substantiated/resolved? • If you have feedback on the goals and stakeholder engagement, you can email ahs.medicaidpolicy@vermont.gov, and they should reference "HCBS COI" or "conflict of interest" in the email subject line.
DMH Update	Nick Nichols, Substance Abuse Program Manager: Suicide Prevention Update • Presentation & document shared, see attachment B • Feedback welcome to Nick • Concerns hared from committee members about loss of civil liberties when a person expresses suicidal ideation. Appreciate empowering lay people to get into conversation about suicide, engage person in discussion, but not with a goal of referring to a professional. Would like to see alternatives to Emergency Department. • Questions? Comments? Nick.Nichols@vermont.gov Brian Smith, Housing Program Administrator, Housing Update • Documents shared- see attachment C • Clarification that Copley house is still viable • Questions? Please contact Brian.Smith@vermont.gov
Public Comment	Would like to hear what crisis teams are like in the state. Is there standardization? Are some not meeting expectations and some exceeding expectations?
Closing Meeting Business	**March Draft Agenda** 12:30-2:30 Opening & Committee Business ○ Discuss timing of meeting- is 12:30-3:30pm working or should the time revert to 12-3pm? ○ Follow up internal discussion related to suicide prevention grant presentation ○ Conversation with DMH: Peer and family input across the board – how is DMH gathering input of peers and family members (AMH SPSC not necessarily representative)? ○ Update on Older Vermonters Working Group (Lynne) ○ Have an AMH SPSC Annual Report ○ Process for reviewing public comments that come in over email to DMH to share with this committee ○ Subcommittee: AMH SPSC process for involvement in agency designation-(if there is an update) ○ Mourning Fox invited to discuss embedded police/MH crisis response?

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	○ Discussions about older Vermonters and mental health needs. Acceptance of lack of services for this population. Would like to hear from DMH about why older Vermonters are de-prioritized. 2:30-3:00 DMH Leadership Update—crisis response & legislative update (S.197) 3:00-3:10 Public Comment 3:10-3:30 Plan April Agenda Should we continue to invite Local Standing Committee members to visit the State Committee? **Motion** to adjourn by Lynne seconded by Michael. All in favor. Motion passes 3:28pm.

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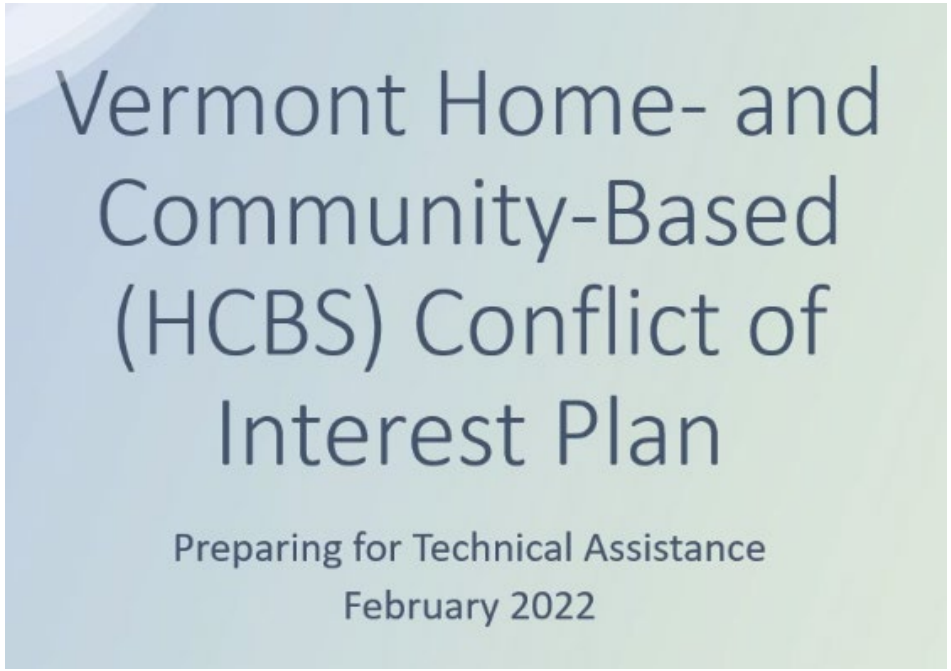
Attachment 1: Presentation by Dylan Frazer



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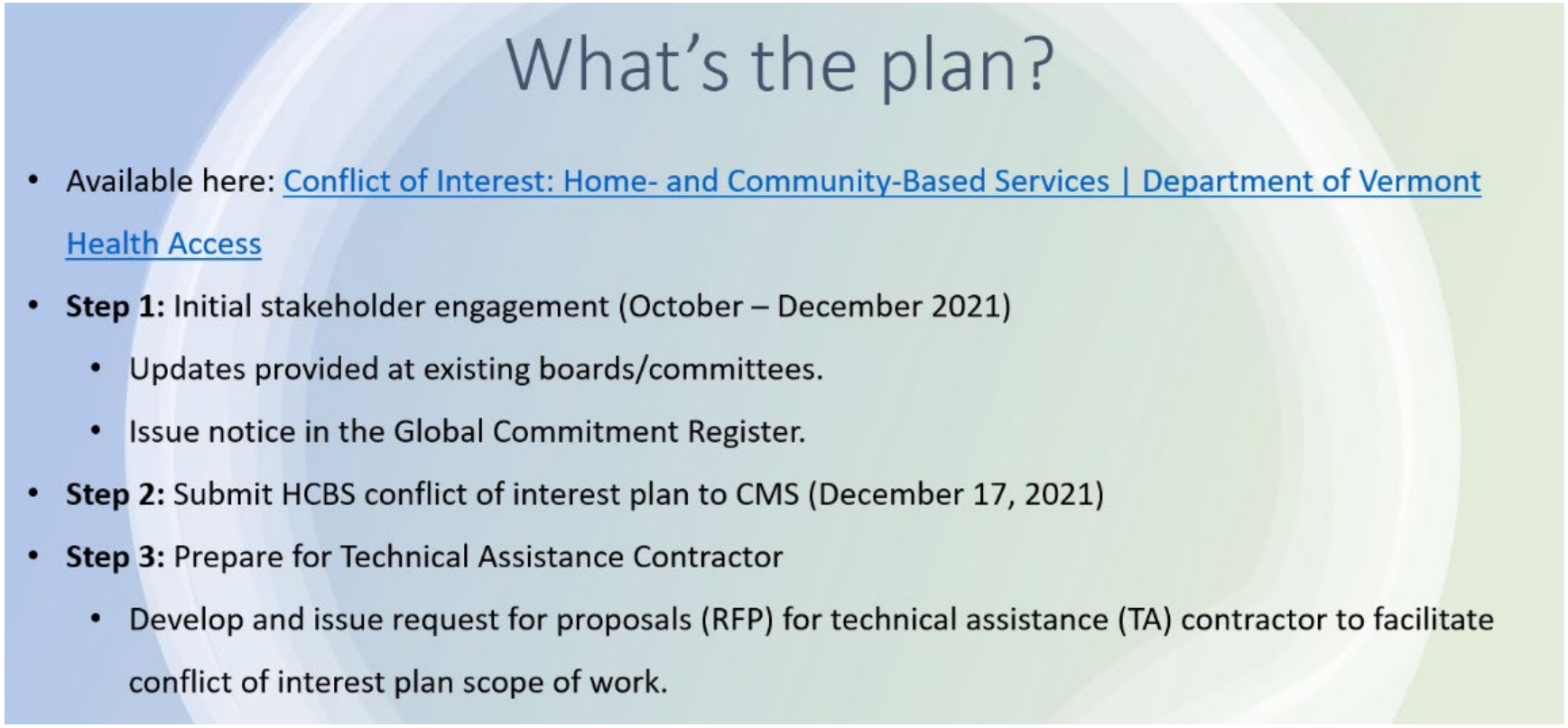
What's the plan?
Available here: Conflict of Interest: Home- and Community-Based Services | Department of Vermont Health Access
Step 1: Initial stakeholder engagement (October – December 2021)
Updates provided at existing boards/committees.
Issue notice in the Global Commitment Register.
Step 2: Submit HCBS conflict of interest plan to CMS (December 17, 2021)
Step 3: Prepare for Technical Assistance Contractor
Develop and issue request for proposals (RFP) for technical assistance (TA) contractor to facilitate conflict of interest plan scope of work.

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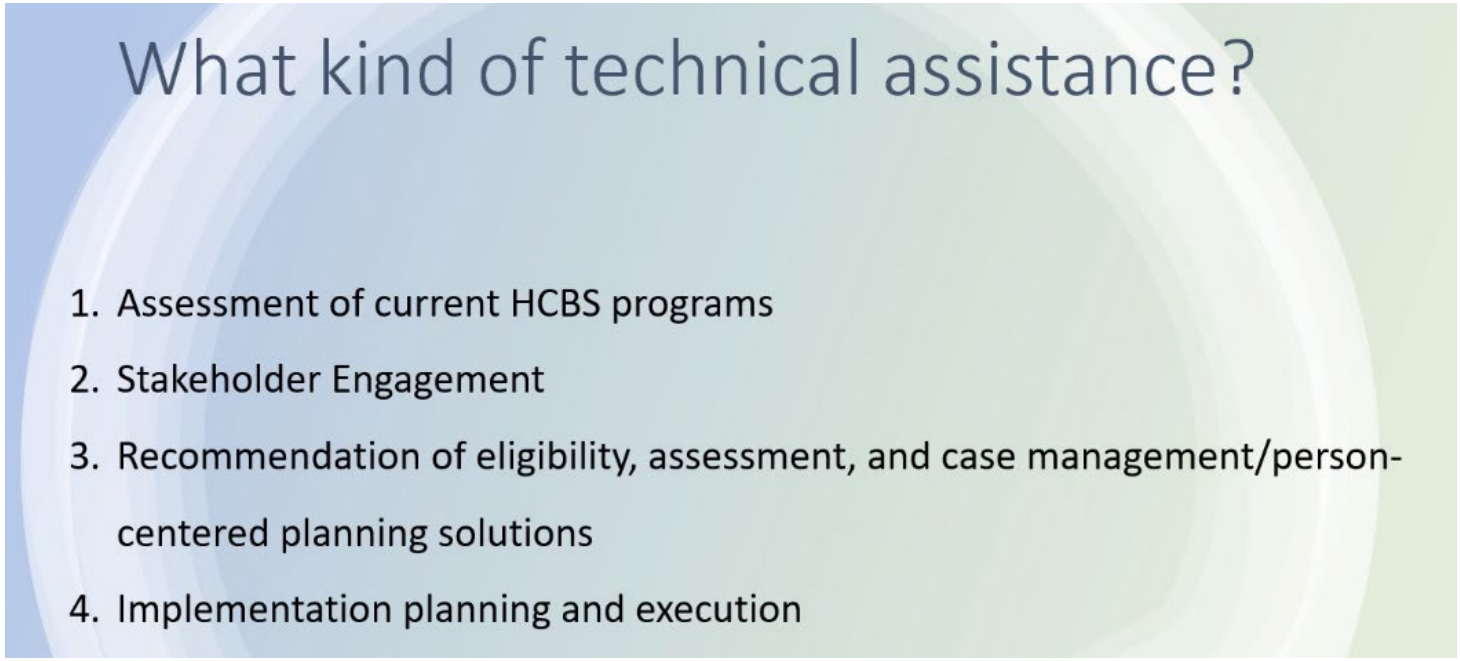

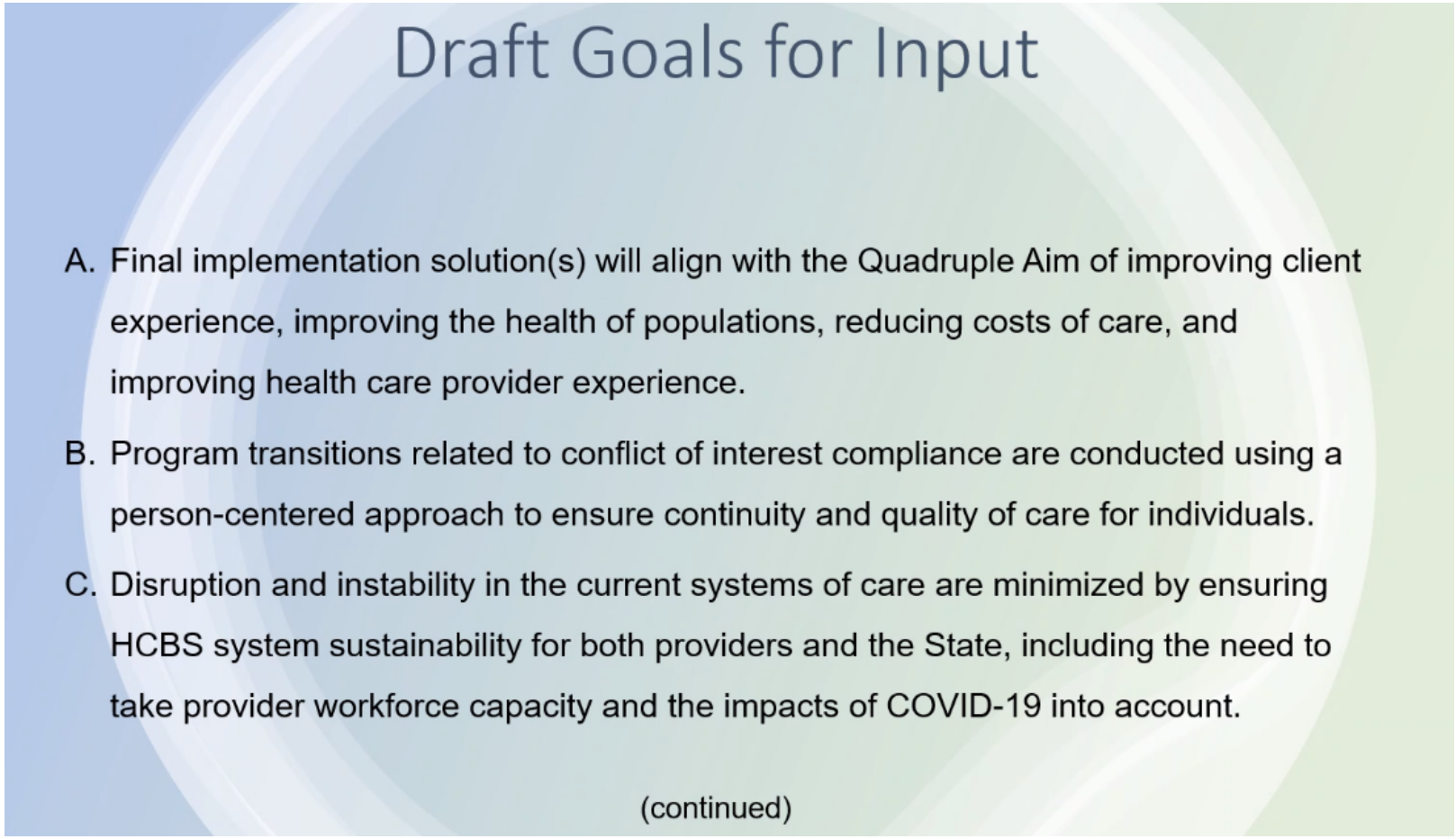
Draft Goals for Input
A. Final implementation solution(s) will align with the Quadruple Aim of improving client experience, improving the health of populations, reducing costs of care, and improving health care provider experience.
B. Program transitions related to conflict of interest compliance are conducted using a person-centered approach to ensure continuity and quality of care for individuals.
C. Disruption and instability in the current systems of care are minimized by ensuring HCBS system sustainability for both providers and the State, including the need to take provider workforce capacity and the impacts of COVID-19 into account.
(continued)

Draft Goals for Input (Continued)

D. Final implementation solution(s) comply with federal HCBS COI requirements which ensure the independence of entities performing evaluations of eligibility, needs assessments, and person-centered plan development.

E. Final implementation solution(s) are aligned across the five specialized programs to the extent possible to reduce administrative burden on individuals, providers, and the State.

F. The stakeholder engagement process is robust, comprehensive, and inclusive.

G. Final implementation solution(s) will consider and align with other case management and care coordination programs offered to Vermont Medicaid members, to the extent possible, to promote care integration across the care continuum and prevent duplication.

Stakeholder Engagement

Goal: The stakeholder engagement process is robust, comprehensive, and inclusive.

- Stakeholder engagement will be ongoing through planning development, and implementation.
- **Stakeholder engagement campaign: Begins January 1, 2023**
  1. Communication that the state is starting a process to assess HCBS programs which could eventually result in program changes.
     - Who should receive this communication and how? General notice? Letters? To whom?
  2. Advisory stakeholder group to offer targeted feedback on HCBS programs and options for change.
     - What should the makeup of the stakeholder group be?
     - How often should the stakeholder group meet?

(continued)

Stakeholder Engagement (Continued)

- **Stakeholder engagement campaign:**
  3. Regional stakeholder meetings throughout Vermont to provide information and collect feedback.
     - How should regional meetings be structured? For instance, who should be invited? What should the topics be? Separated by program?
  4. Alternative modes of informing/engaging with stakeholders:
     - Webinars, Letters, Surveys, Brochures, Interviews, Focus Groups, Other?

- **Formal public comment:** Stakeholders will have the opportunity to provide formal public comment before any significant changes are made to eligibility processes or reimbursement for services.

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Vermont has received a five-year grant from the Centers for Disease Control and Prevention (CDC) to support the implementation and evaluation of the state's comprehensive public health approach to suicide prevention in Vermont.

Overview

The Department of Health, in coordination with Department of Mental Health, will use the federal grant to build on existing partnerships and programs to implement and evaluate a data-driven public health approach to suicide prevention in Vermont. The grant will bolster collective efforts on the integration between healthcare and mental health, and work to ensure all Vermonters have access to the supports they need. Goals will include:

- **Developing a coordinated statewide suicide prevention effort**
- **Improving data analysis to support priority populations**
- **Expanding Zero Suicide, Gatekeeper training, and peer supports**
- **Expanding suicide prevention in Emergency Departments and other healthcare settings.**

- Develop a coordinated statewide prevention effort with state partners and communities.
- Promote awareness of existing suicide prevention activities and programs across the state.
- Utilize data analysis to identify priority populations and to better characterize risk and protective factors impacting suicide.
- Expand the delivery and provision of suicide prevention and safer suicide care for at-risk and underserved populations with a focus on health equity and improved access.
- Expand *Zero Suicide* activities to rural Vermont counties and engage Community Health Teams to support planning to improve screening, treatment, and transitions of care for patients experiencing suicidality.
- Facilitate "Gatekeeper" trainings among social services agencies and community partners to increase the identification of persons at risk of suicide and refer them to treatment or supporting services.
- Expand recovery and peer support groups, including groups for first responders, farmers, and individuals who have lost a loved one to suicide.
- Support the adoption of evidence-based suicide prevention activities in the Emergency Department and other healthcare settings, including *Counseling about Access to Lethal Means,* which focuses on how to reduce access to the methods people use to kill themselves.

For more information:

Organizations and stakeholder interested in engaging with this work can contact *Nick Nichols, Suicide Prevention Program Coordinator*, for more information at nick.nichols@vermont.gov or 802-495-8756.

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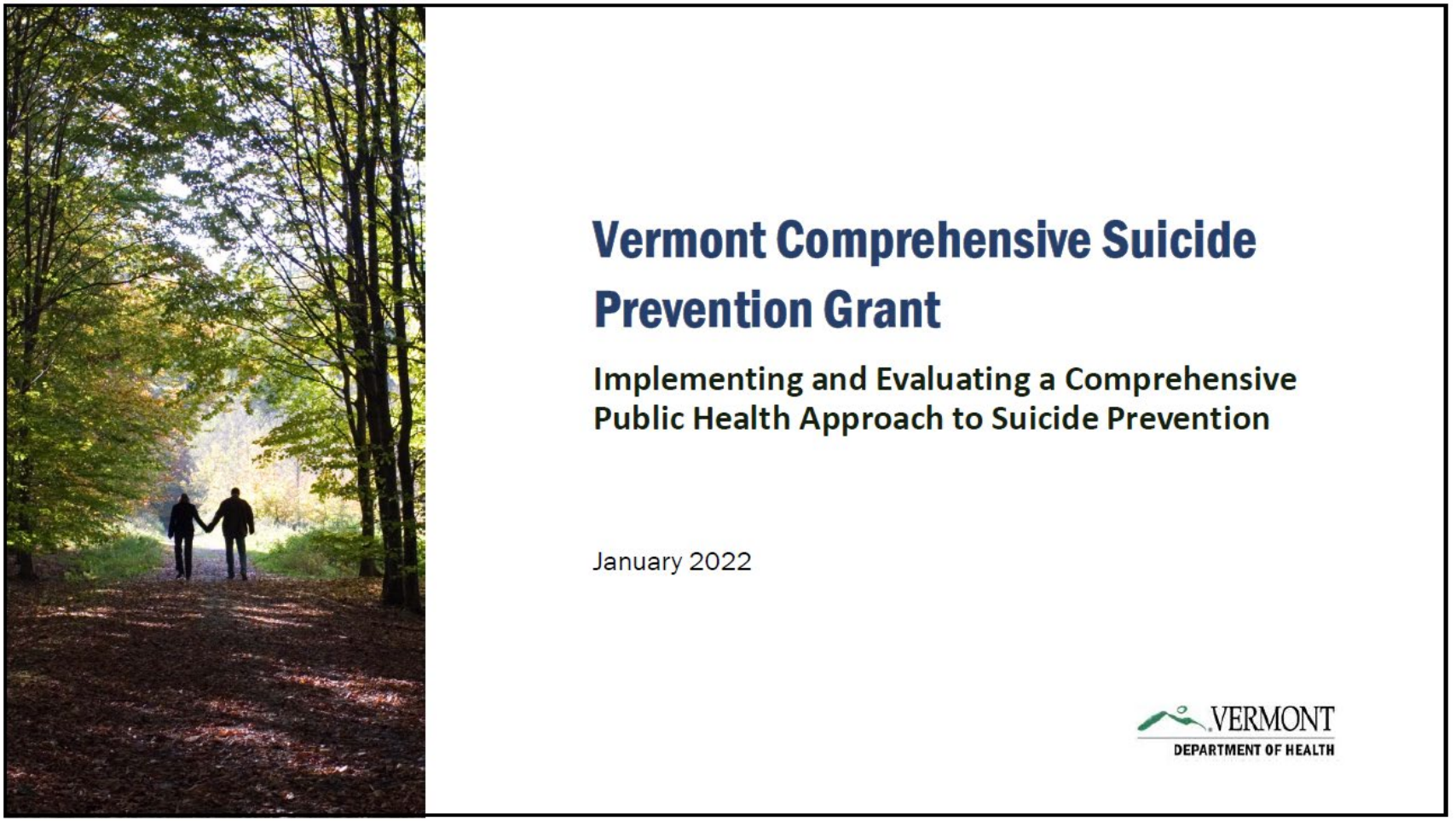

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Agenda

- Background & Grant Overview
- Priority Populations
- Grant Strategies
- Contact Information & Questions

Vermont Comprehensive Suicide Prevention (CSP) Grant Background & Overview

Comprehensive Suicide Prevention (CSP) Grant: Overview

- 5-year grant from Center for Disease Control and Prevention (CDC)
- Grant award to Vermont Department of Health (VDH)
  - Co-Managed by Health Department and Department of Mental Health
- Implement and Evaluate Comprehensive Public Health Approach to Suicide Prevention
  - Improving and protecting health and well-being of communities
  - Emphasis on prevention among large groups of people

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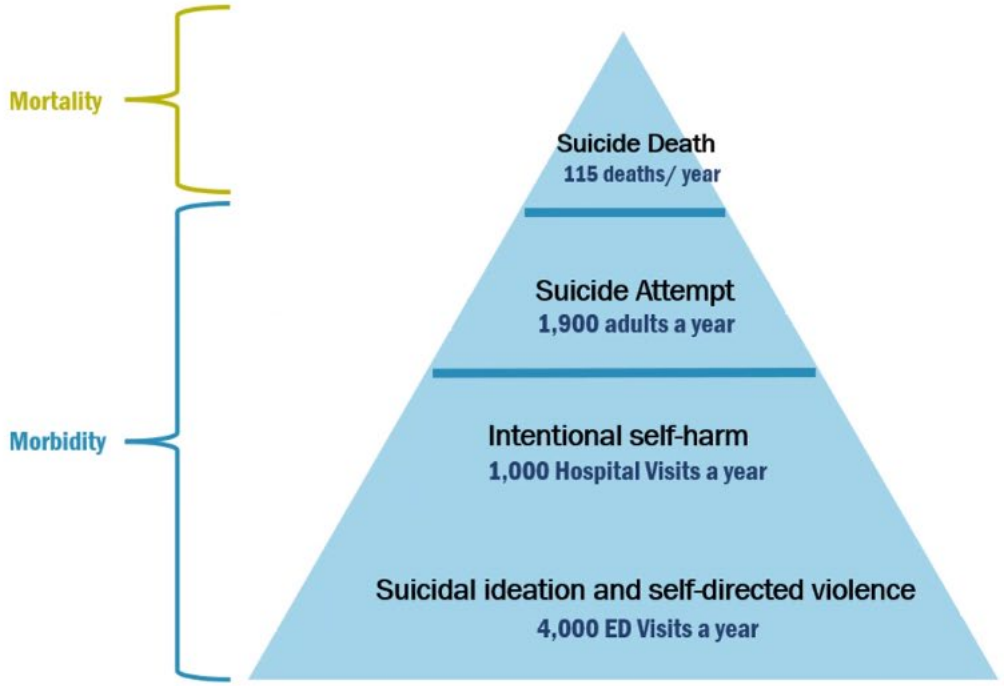
CSP Grant has a goal of reducing suicide morbidity in mortality in Vermont by 10% over a 5- year period.



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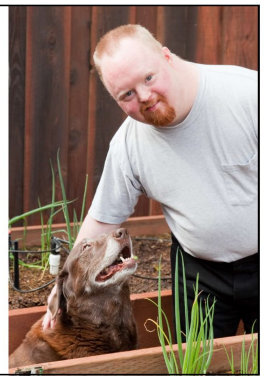
Comprehensive Suicide Prevention (CSP) Grant: Overview

- Expanding and enhancing existing programs
- Multi-level approach:
  - Healthcare and mental health care
  - Community programs
  - Upstream
- Focus on populations and regions experiencing the highest burden of suicide

Priority Populations



Overarching Population
Vermont Residents 15 to 64 years of age

Populations of Focus

Males | Rural | Disability | LGBTQ

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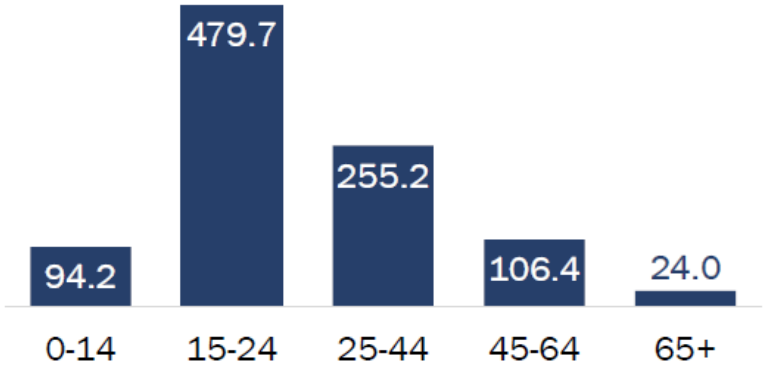
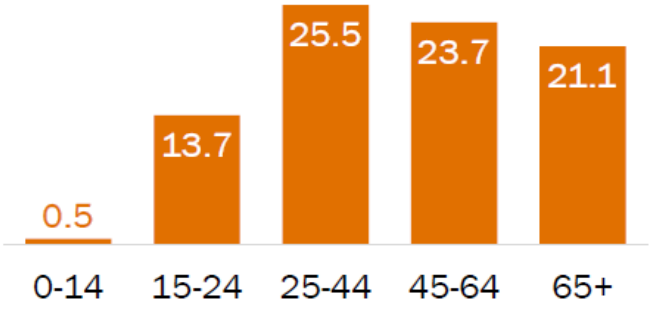
15 to 64 year olds were selected as the overarching population because they have highest suicide morbidity or mortality.

Hospital visits for intentional self-harm are really high for 15 to 24 year olds. *



Suicide deaths are highest for people over the age of 25.



Rates per 100,000 Residents , * Denotes statistical significance.
Source: Vermont Uniform Hospital Discharge Data System, 2017-2018; Vermont Vital Statistics, 2018-2019. Please note at the time of the grant application, the rate of suicide death was lower for Vermonters over the age of 65.

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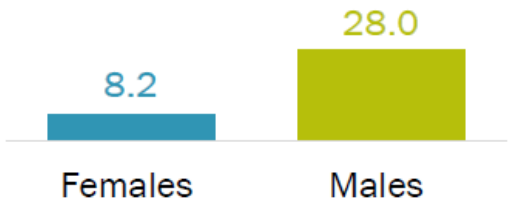
Males were selected as a focus population because they have high suicide mortality.

94 males die by suicide each year, which represent **80%** of suicide deaths.

Males have a suicide rate that is 3x higher than females.*



Death rates per 100,000 Residents, * Denotes statistical significance
Source: Vermont Vital Statistics, 2018-2019 (rates), numbers and percentage (2018-2020).

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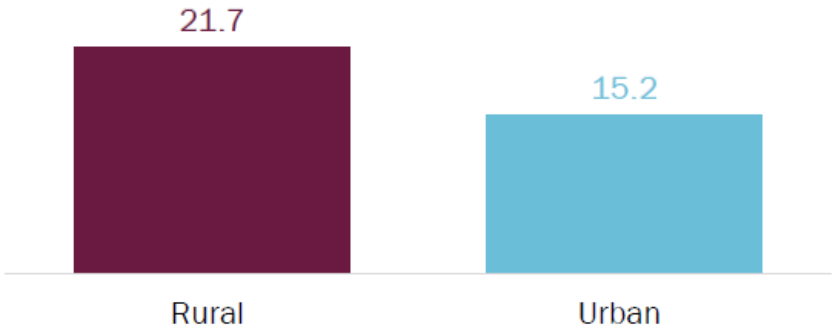
Rural Vermonters were selected because they have high suicide mortality.

95 rural Vermonters die by suicide each year, which represent **81%** of suicide deaths.

Suicide deaths are higher in rural areas compared to urban areas.*



Rural Vermonters are defined as residents living outside of Chittenden County.
Death rates per 100,000 Residents , * Denotes statistical significance
Source: Vermont Vital Statistics, 2018 (rates), numbers and percentage (2018-2020).

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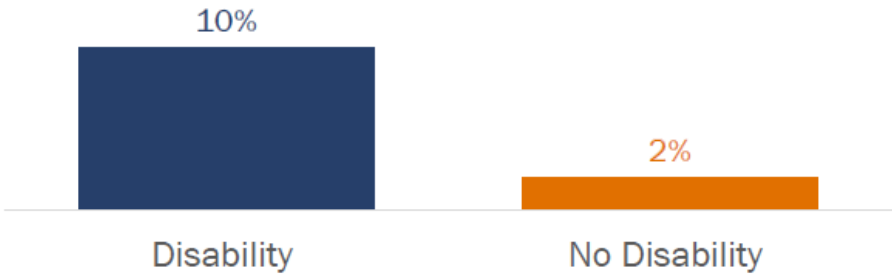
Vermonters with a disability were selected as a focus population because they have high suicide morbidity.

8,400 disabled adults have suicidal ideation, which represent **62%** of adults with suicidal ideation.

Adults with a disability are more 5x more likely to report suicidal ideation compared to people without a disability.*



Disability includes anyone who reports having serious difficulty walking or climbing stairs, concentrating or making decisions, hearing, seeing, dressing or bathing, or who, because of a physical, mental, or emotional condition has difficulty doing errands alone.
*Denotes statistical significance.
Source: Behavioral Risk Factor Surveillance System, 2018

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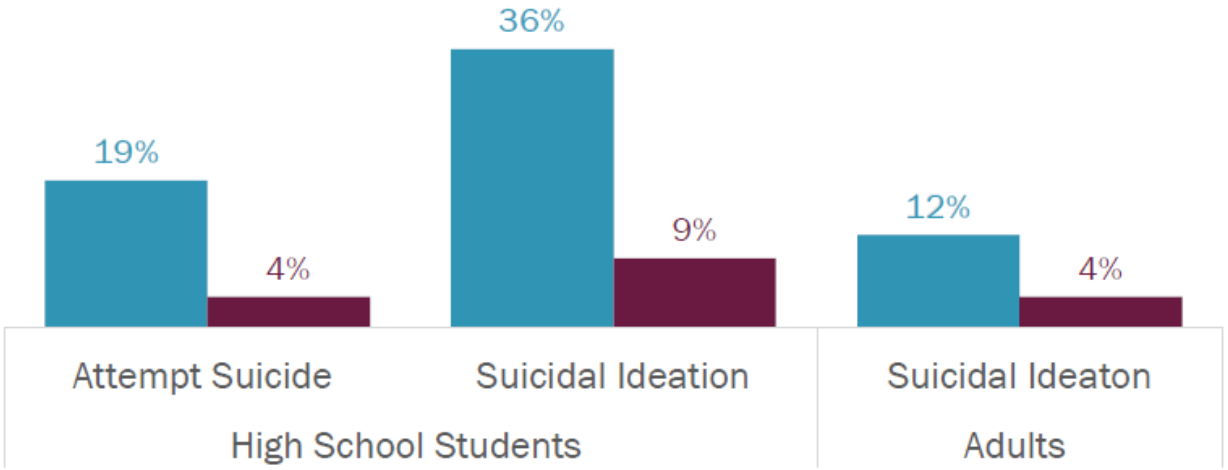
LGBTQ people were selected as a focus population because they have high suicide morbidity.

LGBTQ people are more likely to report suicidal ideation or attempt suicide than heterosexual people. *



*Denotes statistical significance.
Source: Youth Risk Behavior Survey, 2019; Behavioral Risk Factor Surveillance System, 2018.

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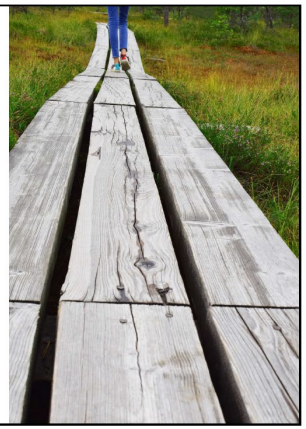
Grant Strategies



Strategy overview

- Expand Gatekeeper training
- Reduce access to lethal means among persons at risk
- Expand peer supports for individuals at-risk
- Improve postvention response to suicide loss
- Expand peer supports for individuals at-risk
- Increase access to mental health care via telehealth
- Increase communications & awareness of suicide prevention initiatives
- Additional strategies

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Expand Gatekeeper training

Gatekeeper Training: Training to identify, support and refer individuals who are experiencing suicidality

Grant Strategies:

- Expand Gatekeeper training capacity for service providers and community partners
- Priority implementation on programs that serve populations of focus
- Availability of different models (Umatter, Mental Health First Aid, ASIST, QPR)
- Focus on sustainability and measuring long-term implementation

Reduce access to lethal means among persons at risk

Lethal Means: objects (e.g., medications, firearms, sharp instruments) that can be used to inflict self-directed violence. Lethal Means Safety (LMS) is an intentional, voluntary practice to reduce one's suicide risk by limiting access to those lethal means.

Grant Strategies:

- Promote Counseling on Access to Lethal Means (CALM) and Safe Storage Messaging

- Identification and mitigation of building structures or landmarks

Expand peer supports for individuals at-risk

Peer Support: a wide range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both.

Grant Strategies:

- Promote connectedness, mutual support, and help-seeking

- Develop/Expand Support Networks and Leaders among populations at risk:
  - First Responders
  - Farmers
  - Suicide Loss Survivors

Improve postvention response to suicide loss

Postvention: an organized immediate, short-term, and long-term response in the aftermath of a suicide to promote healing and mitigate the negative effects of exposure to suicide.

Grant Strategies:

- Lessen harms and prevent future risk among individual who have experienced suicide loss

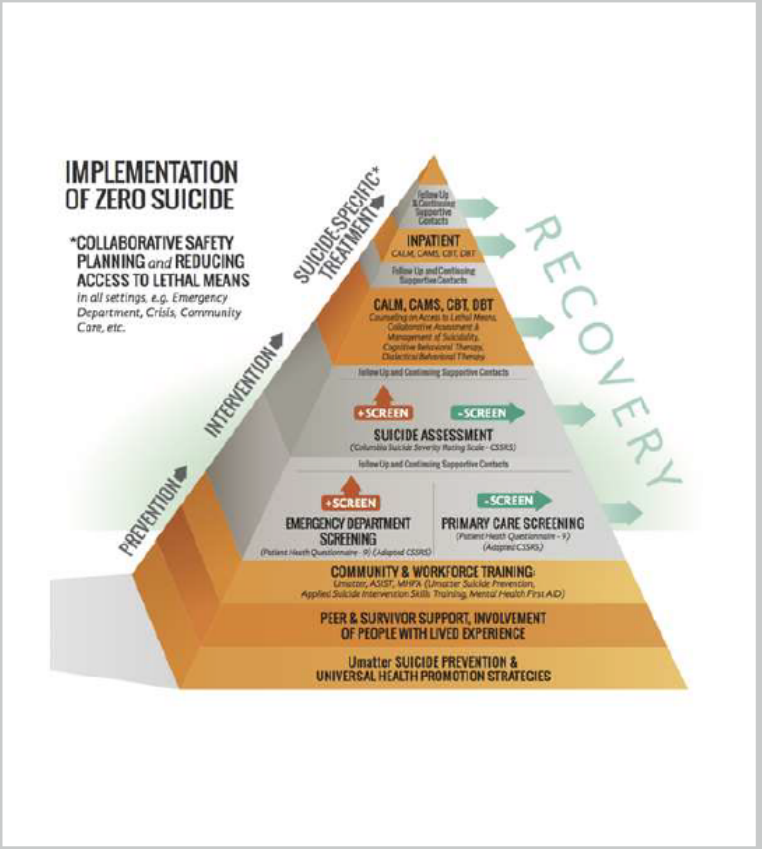
- Develop and implement improved training, resources and community response to suicide death

Expand "Zero Suicide"

Zero Suicide: suicide deaths for individuals under care within health and behavioral health systems are preventable.

Grant Strategies:

- Strengthen access and delivery of suicide care
- Safer suicide care through systems and organization change
- Focus on health care and non-designated agency mental health providers



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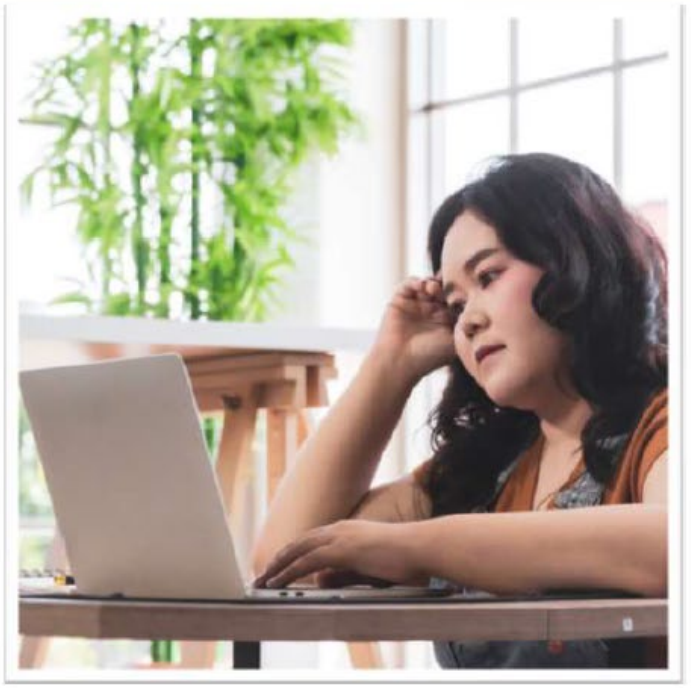
Increase access to mental health care via telehealth

Mental Health Care Telehealth: form of care offered to patients recovering from mental illness through online resources like phones or the internet.

Grant Strategies:

- Focus on rural Vermonters
- Enhance expansion of tele-health to include suicide-specific support and treatment



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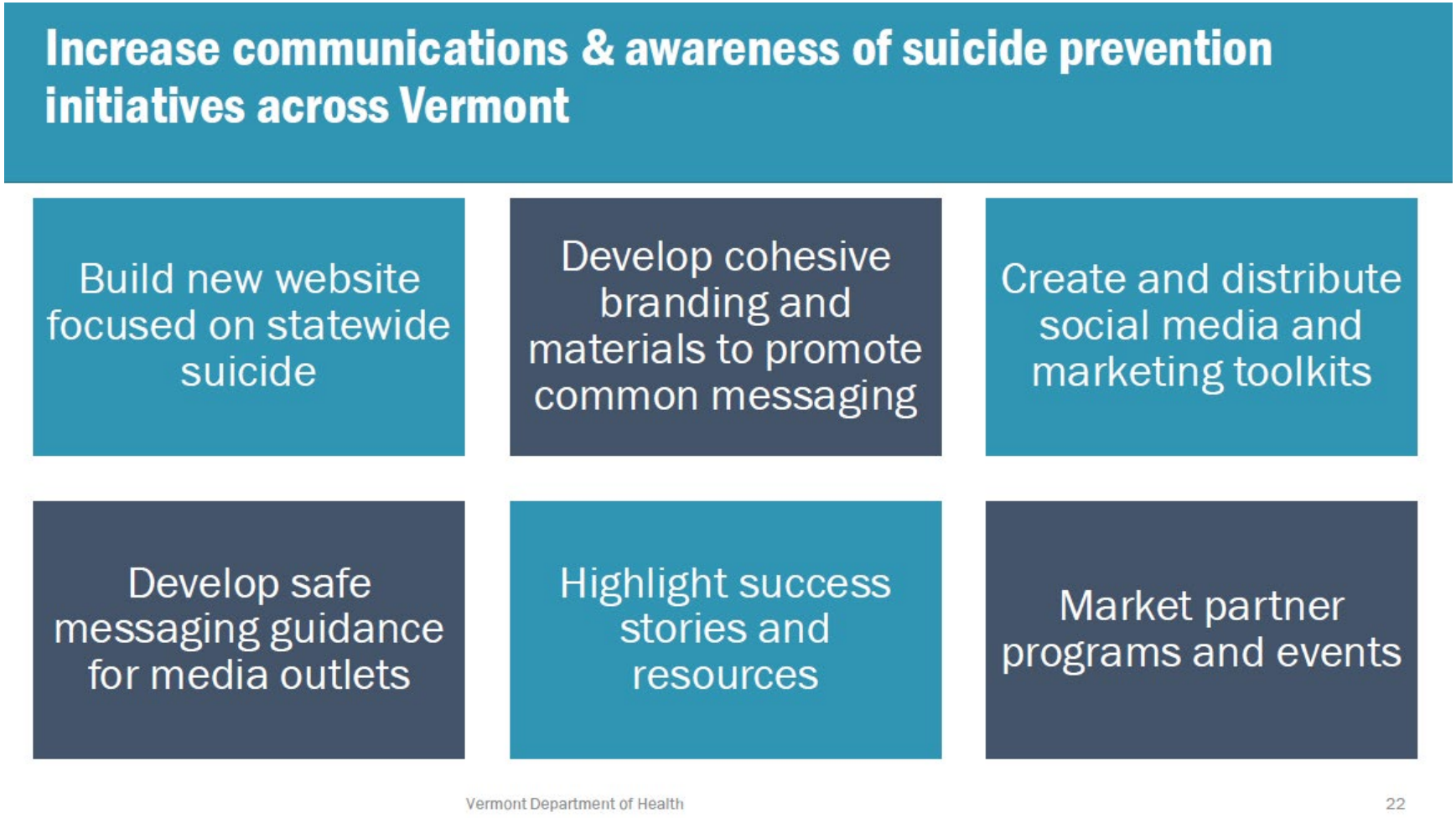

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Additional strategies

Annual stakeholder and partner survey

Comprehensive program inventory

Guide program with data collection and reporting

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Grant Staff

Principle Investigators: Alison Krompf and Stephanie Busch

Program Coordinator: Nick Nichols

Communications/Media Coordinator: Alex Raeburn
Alexander.Raeburn@vermont.gov

Public Health Data Analyst: Caitlin Quinn
Caitlin.Quinn@vermont.gov

Evaluator: Thomas Delaney

Questions?

Nick Nichols, Suicide Prevention Program Coordinator

Nick.Nichols@vermont.gov
Phone: 802-495-8756
Web: Healthvermont.gov

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Attachment C: Housing Update by Brian Smith

DMH Housing and related Grants

1 Federal SAMHSA funded PATH Program (*Projects for Assistance in Transition from Homelessness*) Six DMH statewide grantees provide outreach and engagement services to homeless mentally ill individuals who typically avoid the mental health system of care. Once engaged the agency is expected to refer the person to housing and long-term supportive services. PATH does not pay for any services, only outreach.

2 State VSHA-DMH Housing Subsidy & Care *(DMH-HS&C)*
The Vermont State Housing Authority provides (DMH funded Housing Assistance to Homeless Mentally Ill individuals). The persons served *enter the program from an acute care setting have been homeless at program entry and are awaiting discharge as homeless*. Designated Agencies and SSA PATHWAYS are eligible to apply on behalf of an individual and document eligibility with a service plan in place. DMH determines eligibility and Vermont State Housing Authority administers the funds that are used to pay rents to landlords.

3 State CRT Housing Support Fund
The CRT Housing Support Fund is managed by designated agency housing staff. The program is intended to ensure that an enrolled CRT clients pay no more than 50% of their income on rent while they wait for the HUD Section 8 program. This wait for Section 8 has become longer over time. In addition, this fund assists with security deposits and minimal rent arrearage. Short term loans are an eligible use as well.

4 Federal SAMHSA TTI Grant for the Homeless
The National Association of State Mental Health Program Directors (NASMHPD) funded SAMHSA XXXX (TTI) grant is a more recent award from via NASHMPD two grantees that will test the efficacy of providing stipends to homeless mentally ill when they are engaged and attending MH / SA counseling sessions. This is a two-year grant.

5 Individual Case Consultations provided for Designated Agencies and Pathways Vermont, (HS&C) Subsidy and Care applicants, Care Managers, Vermont State Housing Authority Administration & field staff, Local Not For Profit Housing Developers, (from Tiny Houses to Copley House)

This meeting was not recorded.

6 Housing Development Expansion of individual community housing development need as warranted, in order to explore, create, develop, and preserve housing opportunities in DA community catchment areas across the state.

HS&C Program

Calendar year 2021 only:

Calendar Year 2021 155 clients in total were served and current clients the fund is serving is 140 clients.

Average length of stay was 1,887 and median 1,732 days.

There were 15 exits with only 5 negative destinations.

Since HS&C program inception in Dec. 2011:

280 served since Dec. 2011.

The lengths of stay in housing since the program began range from 0 days for those more recently enrolled to 3,646 days for long term stayers.

The lengths of stay in housing since the program began average 1480 days with the median stay being 1,118.

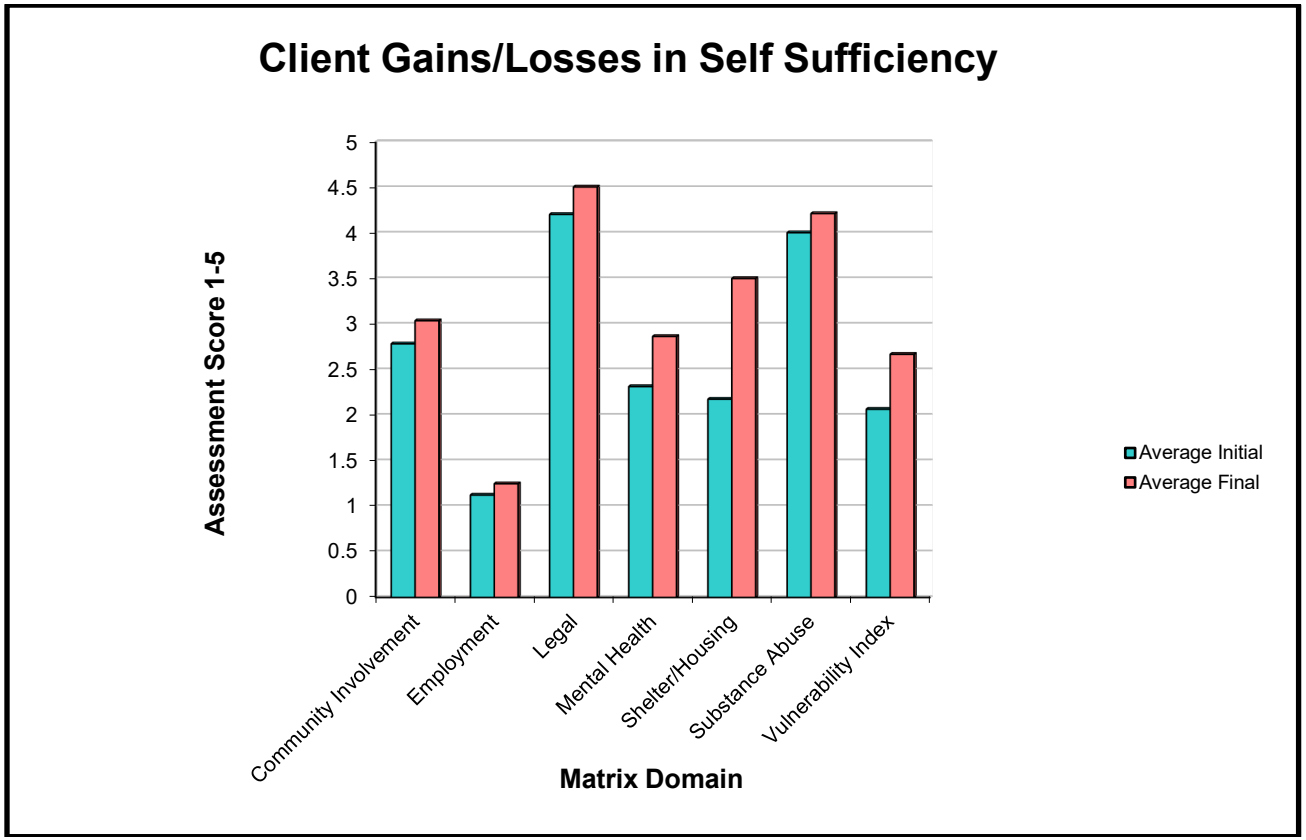
Slightly more males were served, 158 vs 114 female of known genders.

Of the 280 served, more than 87% (243/280) were literally homeless and exiting an acute care bed or temporarily housed, meaning having come from the streets, an emergency shelter, or staying in temporary housing such as hospitals/jails.
38% (106/280) were chronically homeless in places not meant for habitation or emergency shelter prior to entering the Housing Subsidy & Care

Of the 280 housed since December 2011, 144 have exited. 39 of the 144 have positive destinations and 23 are deceased.

This meeting was not recorded.

SSOM MEASUREMENT OUTCOMES GRAPH:



This meeting was not recorded.

Data behind the graph:

HS&C

Program Averages					
	Domain	**Initial**	**Recent**	**Change**	**%**
1	Shelter/Housing	2.177	3.5024	1.3254	60.9%
2	Employment	1.1244	1.2488	0.1244	11.1%
12	Community Involvement	2.7847	3.0383	0.2536	9.1%
14	Legal	4.2057	4.5072	0.3014	7.2%
15	Mental Health	2.3158	2.866	0.5502	23.8%
16	Substance Abuse	4.0048	4.2153	0.2105	5.3%
90	Vulnerability Index	2.067	2.6699	0.6029	29.2%
	Average:	**2.6685**	**3.1497**	**0.4812**	**18.0%**