This meeting was not recorded. Six members are needed for a quorum.

9/12/2022
Adult State Program Standing Committee Minutes **DRAFT**

Present Members: ☐Bert Dyer (he/him) (ex) ☒ Malaika Puffer (she/her) ☐ Ward Nial (he/him) ☐Kate Hunt (she/her) (ex)
☒ Marla Simpson (she/they) ☐Dan Towle (he/him) (ex) ☒Lynne Cardozo ☒Zach Hughes (he/him)
☒Christopher Rotsettis (he/him) ☒Ann C Cummins (she/her) ☒Michael McAdoo
☐Erin Nichols (they/she) (resigned September, to be removed before December if not returned)
DMH/State Staff: ☒Eva Dayon (they/them) ☒Dr. Trish Singer (she/her) ☒Dr. Kelley Klein (she/her) ☒Alison Krompf (she/her)
☒Katie Smith (she/her)
Public: ☐Yuri R ☐Jin Li Chan ☐Dillon Burns ☒Alexis McGuiness (she/her) ☒Bruce Wilson
HCRS Staff: ☒Anne Bilodeau, COO ☒Linda Simoneaux, Asst. Director of Adult Services ☒Kate Lamphere, Director of Adult Services
☒Dr. George Karabakakis, CEO ☒Jack Heddon, Windham County Emergency Services

Agenda
12:30 SPSC Business:
- Standing items: introductions, review agenda, announcements, vote on previous meeting minutes and public comment
- New items: Prepare for HCRS Designation visit

1:00 DMH Leadership Update with Alison Krompf and Dr. Kelley Klein: General Updates, Alternatives to Emergency Departments, Polypharmacy
1:30 Break
1:35 Health Care and Rehabilitation Services (HCRS) Agency Visit
3:00 Draft Recommendation Letter to Commissioner
3:15 Public Comment
3:20 Next meeting draft agenda and closing meeting business

Agenda Item	**Discussion** (follow up items in yellow) **Facilitator: Marla** **Timekeeper: n/a**
Opening and AMH SPSC Business	Meeting convened at 12:35pm. Members discussed how to prioritize and ask questions of HCRS visitors later in the meeting. **Motion** to allow public comment through the meeting with discretion, allowing public to ask questions. Seconded by Lynne. No opposed or abstentions. Motion passes.

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DMH Leadership Update:	**<u>Conflict Free Case Management</u>**- Center for Medicare and Medicaid Services (CMS) oversees Home and Community Based Services (HCBS)- designed to protect individuals with high support needs in home and home-like settings. This includes the Community Rehabilitation and Treatment (CRT) program with is 'HCBS-like' since most individuals don't actually meet the threshold for high needs as defined by the HCBS rules, such as living in housing staffed by the agency. CMS has allowed Vermont to be an exception to conforming with the HCBS rules for the CRT population since it is not an exact match for the intention of the policy. That exception has recently changed. One of the requirements Vermont will need to conform with is having conflict-free case management. Conflict-free case management means a client would need to have their clinical assessment, treatment plan goal setting, and services proscribed by a different person than those providing services. The assumption behind this policy is that there is an incentive to over-proscribe services or only proscribe services available at the agency providing them. Over proscribing is a moot point in the current funding system in Vermont since agencies are paid a flat rate per member per month regardless of how many services are provided. There are other known potential benefits and challenges to this separation. The current step in coming into compliance with this measure is looking for technical assistance (TA) from an entity outside the State of Vermont Agency of Human Services to identify potential solutions to come into compliance that maximize benefits and minimize challenges. After the TA entity is selected (early fall 2022), the TA support will start with stakeholder engagement- anticipated in winter 2022. Ways for Vermont to potentially come into compliance may be: • Create a 'firewall' within an agency wherein service coordination/treatment planning is done in a different department than services provided • Contract with an outside entity provide service planning (which could be another Designated Agency) • Reassess how much of the CRT program actually meets HCBS criteria and create a plan for this sub-population DMH discussed with the committee how the current grievance process should be a layer of protection for current conflict in case management. There was also discussion about the new burden on clients (when conflict free case management is implemented) to share their story with a different staff they see once a year or less for service planning, and the barriers of updates to their plan between annual visits. DMH will share the stakeholder engagement information with this committee when it commences in winter 2022. **<u>Poly pharmacy</u>** – What is considered 'reasonable' is dependent on the individual's needs, and that they have informed consent about the risks, benefits, and alternate treatment options for each medication proscribed.

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HCRS Designation Q&A	AMH SPSC Questions in Black, responses from HCRS in blue. 1. Was there a rationale why the only **board members** present were officers? No. Some board members went to other site visit meetings such as the standing committee they serve on. 2. Please tell us more about: a. What is the **HealthWorks** collaborative? Collective of four organizations (HCRS, Brattleboro Retreat, Brattleboro Memorial Hospital, Groundworks) working tougher to support individuals in Windham County who are homeless or unstably housed. b. **Mobile crisis** outreach and support? See below. c. Collaboration with local **law enforcement**? Embedded workers in many local departments and the state police. Involve police in reach out only when necessary. Embedded police liaison- critical during periods of challenging behaviors, impacts how police serve warrants. Want to ensure informed responses and reduce trauma when police do need to be involved. d. What is the **life enrichment center**? Drop-in space in Springfield, VT. Recently re-opened (has been closed due to COVID-19). 3. The report did not have many details about the use of peer support at HCRS. Can you give more detail about your use and plans for peer support in the future? HCRS has expanded peer support recently. There is a peer support advocate team (8 people employed currently, a few open positions). Currently, peer workers support individuals in adult and DS programs, expanding to include youth. Important to support individuals and advocating for policies, procedures, culture at agency and broadly in the state. Want to create alternate resources for people in crisis. When there are conversations about new programming (such as working with first responders)- one of the first steps for HCRS as an agency is to incorporate peer support/peer voice. 4. Regarding HCRS' working relationship with Brattleboro Retreat - what's working? What could be improved? From a residential perspective- the Brattleboro Retreat sends many referrals (what's working). Would like to improve timely sharing of information from the Retreat to HCRS. Number of temporary staff at Brattleboro Retreat make ongoing relationships a challenge. 5. Tell us more about the Groundworks homeless shelter- what efforts has HCRS taken to reduce homelessness in your region or support homeless clients? Comprehensive and integrated- see information about Healthworks Collaborative.

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	6. DMH staff identified your agency as a model for the state for forensic Orders of Non-Hospitalization (ONH). What do you think you are doing differently? What's working? ONHs used to be viewed like probation- the agency had to be role of 'enforcer' which didn't feel client-driven. Now renewals are presented to the Human Rights Committee to ensure the plan meets statutory requirements, consider the client's desires, and consider alternatives to ONHs. This has improved relationships with individuals in services. This is an example of making the agency's operations come into alignment with the philosophy of care. Kudos on the work HCRS has done to reduce unnecessary Orders of Non-Hospitalization. 7. HCRS reported recently completing an 'analysis of clients residing in higher levels of care' to improve outpatient supports (p. 10). a. Could you please share a copy of this report? No, this was a very small population and there is too much identifiable information therein. b. What interventions are you planning to address this? What we learned from this report is that there is an overlap between people in DS program that also have mental health service needs. Working on adding a new clinical position that spans both programs to support this community. c. How does your rate of hospitalization compare to other regions of the state? Don't know how we compare to other regions of the state at this time. d. What are you doing to reduce Emergency Department (ED) visits and the associated long waits in Emergency Departments? Try to encourage diversion first- calling service provider first when not in imminent crisis. Also advocating for people to get access to services they need while they wait. Implemented open access- this has made it easier to get a quick intake assessment while people are waiting in the ED. Did some training with the Wildflower Alliance to support people in how they think about suicide. HealthWorks ACT team (which is planned but hasn't started yet) is specifically tasked with reducing reliance on EDs. Working on a specific alternative to the ED for youth. e. Can you talk more about the concept of Huddles in the ED? What community partners recommended daily "huddles" for people in the ED? What would happen and be accomplished with more "huddles"? Huddles happen daily or twice daily for transition and safety planning. 8. Adult Outpatient surveys show lower improvement upon discharge at HCRS versus the state average for fiscal year 2018-2020 (p.12). Do you have any insights on this? Curious how the statewide response rate plays into this- there is a higher response rate at HCRS. Also, there could be more administrative discharge from HCRS. HCRS is having conversations about discharge earlier in treatment.

	9. HCRS reports slightly less community support services but more medication and medical support services for CRT clients compared to the state average. The opposite is true for adult outpatient services. Any ideas on what might be behind this data (p. 11-12)? HCRS doesn't do medication support in Adult Outpatient. HCRS does have nursing services provided by nurses- is this same service is provided by non-nurse case managers at other agencies this could skew the statewide rates. 10. Staff in qualitative feedback to surveys mentioned wanting pay for performance at HCRS. How would that work in practice (p. 13)? This would look like differential raises for differential performance at review time. This has not been discussed as a goal of HCRS leadership- instead have given universal increase to all staff when funds are available. There is a union at HCRS, which has advocated for an across-the-board increase. 11. Any ideas on why the response rate for the adult local program standing committee survey was so low? Likely due to participation slow-down during COVID-19 pandemic. Currently trying to recruit more individuals to the committee. 12. Spread of services looks different for Emergency Services clients at HCRS than statewide averages (p.16). Why might this be? Likely this is because bed checks are coded as community support services. 13. Why do you think the response rate from Emergency Services staff to DMH surveys was low (p.16)? The survey was sent to every crisis staff. 14. Are advance directives used by HCRS? Are they useful? They are useful when they are specific to services provided or during a crisis. These components aren't always included. Not many people have psychiatric advance directives. All adult clients are asked about whether they have one at intake and again yearly. The forms aren't done at HCRS, clients are referred to an outside entity to complete them. 15. Would you please share the strategic plan for HCRS? Proud of the recently completed strategic plan- first priority is justice and equity to be embedded in all efforts. Included board, staff, people served, community. Seven pillars shared. Board was well engaged through process. 16. What is working in coordination between Vermont and New Hampshire? What could be improved? HCRS has had a few opportunities for coordination, work with Dartmouth Hitchcock Medical Center, West Central Behavioral Health. We also serve NH residents that cross to receive services from VT hospitals. There are people who move

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	back and forth over the border (work in one, live in another), which is challenging- HCRS tries to provide continuous care. NH Medicaid can be accepted in HCRS if needed. 17. Are meditation and yoga offered to clients? Yes, there are groups for mindfulness and meditation and this can happen in individual session. There is a staff yoga group. Looking to expand access to yoga for clients. 18. In terms of cultural responsiveness - where do you envision taking the agency in the next 5-10 years? This is intentionally our first strategic priority. Already have a Justice and Equity committee at the agency. Working with a consultant to create a more inclusive work environment for people from diverse experiences. 19. Do you have a staff wellness initiative? How is staff morale? Robust wellness platform exists online, there are physical/mental health challenges at the agency. We pay for the headspace (meditation) app for all staff. There are per diem jobs but most are full time. HCRS is very flexible with residential staff, want to hire folks with residential experience- full time work doesn't work for everyone. Peer support positions are often flexible to be part time or full time based on the needs of staff applying. 20. One non-supervising program staff said, "those who work at HCRS are heroic in their dedication to helping others" (p. 12). Can you give an example? Pound of staff working in residential especially- short staffed, with COVID-19 precautions, pitching in with per diem when they have other roles at the agency. Staff believe in the work even on the challenging days. Some staff covered long hours each week during short-staffed periods. Try to balance this with time off and paid leave so they don't burn out. Workload is ongoing even through short-staffed periods. HCRS appreciates the AMH SPSC for sharing questions in advance. We have a phenomenal team of staff and feel lucky to work with the clients we do. We try to be creative in support of staff so they can continue to do this work. 21. What's it like serving a broad geographic area? Telemedicine has been helpful. There are many different communities and types of communities. There are two full crisis teams since the geography is too far. Five hospitals in region along with two psych inpatient units. There are many meetings to coordinate with this many stakeholders. Kudos shared by committee as noted in the last meeting minutes.
Draft Letter to Commissioner	Members reflected on the experience of meeting with HCRS Staff. **Motion** to Redesignate by Ann. Seconded by Zach. Discussion occurred. All in favor with one abstention. Motion passes.
Public Comment	Would like an explicit question for all agencies about Diversity, Equity, and Inclusion.

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	Request to share at a future meeting: • what policies does DMH have around DEI? • Is this a focus at the agency? • How is this considered in ongoing work? Well done meeting, informative. Bruce submitted an application through Steve DeVoe- this will be shared with the membership subcommittee.
Closing Meeting Business	**Motion** to approve August minutes made by Zach, seconded by Christopher. All in favor, one abstention. Passed. **Next Meeting Draft Agenda** 12:30-2:30 Opening & Committee Business & Vote on Alexis' application 2:30-3:00 DMH Leadership Update: Adult Care Management? More conversation with Dr. Klein – would like to know about scope of role of medical director. What is on the docket right now. Perspectives/feedback relative to that. Eva to send job description for medical director position to committee. *Continue conversation about CFCM as appropriate in future months. 3:00-3:10 Public Comment 3:10-3:30 Plan Next Agenda Vermont Psychiatric Survivors is having an annual meeting on October 29. More information to come. Alyssum is having an Open House on September 16. October discussion items • SPSC System of Care Priorities for Fiscal Year 2023: ensuring each item has a short description (30+ minutes) • Have an AMH SPSC Annual Report? • Conversations over email / reminder to use norms (assume positive intentions, speak kindness, listen to understand). Are emails public? ○ How/when to speak as an individual or committee member • Zero Suicide – seek to understand committee member's positions on this project **Motion** to Adjourn by Zach, Seconded by Michael. All in favor. Meeting ended at 3:28pm.