DAIL Advisory Board Meeting Minutes
June 9, 2016
Sally Fox Conference Center, Waterbury

ATTENDEES:

Board Members: Linda Berger, Robert Borden, Peter Cobb, James Coutts, Nancy Lang, Nick McCardle, Nancy Metz, Virginia Milkey, John Pierce, Steven Pouliot, Beth Stern

Guests: Matt McMahon, MMR and Jackie Majoros

State Employees: Taryn Austin, Jaskanwar Batra, Joanne Fleurrey, Camille George

Motion to Approve Minutes: 05/12/16 minutes: Approved: Peter Cobb
Seconded: Steve Pouliot
Abstention: Nancy Lang

Review and Approval of Meeting Minutes

Nancy Brieden was not in attendance as she was attending the Supported Decision Making conference put on by VT Cares.

Camille George presented Peter Cobb a certificate of appreciation for his many years of service on the DAIL Advisory Board.

I. **What is on the Horizon – Insights into Vermont's Home Health Agencies and the Vermont Association for the Blind and Visually Impaired**
Peter Cobb, Executive Director, Vermont Assembly of Home Health Agencies and Steve Pouliot, Executive Director, Vermont Association for the Blind & Visually Impaired

VAHHA – Peter Cobb shared where we were, where we are and how we got here. In 1980, the Agency of Human Services adopted their first Long Term Care (LTC) Policy that stated "the purpose of a long term care system is to provide a local structure which is able to arrange, manage and coordinate the provision of in-home, community based and institutional services and to ensure that people who need long-term care receive that appropriate types and levels of service in the least restrictive settings and in the most appropriate and cost-effective manner." This policy was based on the belief "that the long-term care client should have an existence which, to the greatest extent possible, is characteristic of a life-style that would be normal for a person of similar age".

The Joint House/Senate Committee on LTC that met during the summer of 1985 agreed with the policy set for the by Agency. The committee found that Medicaid limitations on payments for home and community-based services inhibit the development of a community based delivery system by directing funds toward institutional care.

In 1986, H.589 was passed. This bill directs AHS to apply for a Medicaid waiver. A waiver will permit Medicaid funds to be used to help the elderly and disabled who require long-term care to receive that care at home. The waiver, once obtained, will move Vermont in a direction to accomplish the principles and goals set forth in the policy of 1980. This year celebrates the 25th anniversary of the waiver.

In 1991, the Department of Aging and Disabilities (DAD) came up with a program tax community – but that never came to fruition. Then, DAD developed the "Shift the Balance" report. At the time nursing homes comprised of 80% of the aging populations and 20% in the community. The goal was to change that to 30% and that percentage has been far surpassed.

Peter noted that no matter who comprises the Administration, the work at DAIL still gets done. The staff is what keeps the programs going. Also, keeping the vision the same has actually made things happen. Although there are so many outside forces, trends, politics, keeping the vision the same within all these dynamics is impressive.

Peter closed with his personal experience with the Choices for Care program. He said getting on the program is difficult and time consuming. No one aspect seemed more onerous than another, it is just a process, a bureaucratic one at that.

Also noted that Claire Buckley from KSE will be attending after Peter's retirement on June 30th. Her contact information is cbuckley@ksepartners.

VABVI – Steve Pouliot his "Where we were, where we are and how did we get here" on the Vermont Association for the Blind and Visually Impaired (VABVI). When VABVI began, fundraising was the major job duty, until needs began to change. VABVI started working with their clients on finding jobs when the Division of Blind and Visually Impaired (DBVI) was formed, the focus changed. Staff was added to focus on the rehabilitation it takes to remain in their homes and community. They now have 4 offices throughout Vermont.

When VABVI started the focus was on adults with visual impairments. In the mid 1980's they started to add services for children, too. In the late 1980's their volunteer program began. The need for volunteers was mainly for drivers and that need is still the most need volunteer today. No longer being able to drive is one of the hardest things for folks to lose as they lose their vision. After training, however, almost everyone who that concern now felt confident that they could stay in their home.

In the 1990's the PALS Group began. It offers group services (e.g. money identification) and a peer portion. This provides folks a chance just to talk to others that are going through similar things. Swapping tips to one

another, sharing what works for someone in different situations. This portion also establishes friendships, as most people with visual impairment feel a great deal of isolation.

VABVI serves approximately 1,400 people (1,200 of them adults). This is about 60% more that it was a decade ago. They have had one federal grant that has been the same amount for at least 24 years. This grant flows through DAIL's Division for the Blind and Visually Impaired. The State of Vermont supplements this amount but this is being stressed and stretched more and more. The amount from the state has not increased in 11 years.

When people come into VABVI for services, they complete a survey for what services they are looking for and what they are hoping to gain. Services are not decided for the individuals; they ask for what they think they need. About 25% mark in their file that they may need to change their living situation. People that are blind or visually impaired are 15 times more likely to move to a nursing home that a person with vision.

As our technology advances more and more, many request technology training. But VABVI does not have the time nor the resources to address this. They can only provide a list of devices and apps and hope for the best. One of the newest apps available clips to glasses and attaches to a device about the size of a cell phone. The app can describe what is around them. It can read store and street signs. Giving the user a feeling of great independence and less disorientation. Because Medicaid only covers the cost of glasses for this population, few can afford to have these devices and apps. This fight is being fought at the national level. Even though technology has improved and assisted many people that are blind and visually impaired, Braille is still advocated for. This is always a fight because people feel it is no longer necessary due to technology. Steve likens this to not teaching any child to read because there is technology that can do that for them.

The causes of vision loss have not changed much over the years for adults. But for children there has been a significant one. It is called Cortical Visual Impairment (CVI). This is a result of many more premature babies being delivered and surviving. The optical nerve is not fully developed, therefore resulting in possible CVI. Teachers have been getting more training on this issue and developing ways to help strengthen the connections to the nerve.

When asked if the challenges and opportunities have changed over the past 20-30 years, Steve said "No". Money will always be a challenge. Jobs associated with visual rehabilitation in Vermont are paid less than nationally. Finding volunteers is more difficult as people have less free time – they are working later in life, etc… One great opportunity is the Master's Degree program in Visual Impairment offered by UMass. The cost is very low and the time commitment is only 2.5 years.

II. **Deaf, Hard of Hearing, DeafBlind Council (D/HH/DB) and S.66 Update**
Bill Hudson, DAIL, Division for Vocational Rehabilitation

A bill, S.66, was introduced last year (February 2015) for this council to be created, but the original focus was mainly on children. The bill went back to the Senate Government Operations Committee

to expand coverage of this bill to recognize birth to elderly lifespan needs impacted by hearing loss. This change was supported by the Senate Government Operations and then the House Human Services committee. The Council letter explains that the focus should be on four areas: birth – 3 years, school age, adults, senior citizens. This letter also explains the definitions of several hearing loss groups impacted,

Per national data, there are approximately 57,000 Vermonters living with full or some type of hearing loss. There is very little tangible data on this population in Vermont. Other than the birth – 3 years' age group, there is very limited data. What is known is that children feel very isolated in school. The services and gaps in service differ for each age group. Also, finding a list of resources is very difficult.

S.66 was signed into law on May 16, 2016 by Governor Shumlin. The D/HH/DB council is part of DAIL and are recognized as a working advisory council with no sunset provision in order to continue the Council work that requires more time. Because there is so little data, services and list of resources currently, the focus will be to collecting data, making recommendations and suggestions, and sharing what they see happening in this population. The council recommendations will go to the Governor or General Assembly. The council will consist of 16 appointed members with a variety of hearing loss background, parents, educators, etc, along with 4 State members.

These are as follows – taken from the bill "As Passed by House and Senate Official":

§ 1602. VERMONT DEAF, HARD OF HEARING, AND DEAFBLIND ADVISORY COUNCIL

(a) Creation; purpose. There is created a Vermont Deaf, Hard of Hearing, and DeafBlind Advisory Council to promote diversity, equality, awareness, and access among individuals who are Deaf, Hard of Hearing, or DeafBlind.

(b) Membership. The Advisory Council shall consist of the following members:

(1) sixteen members of the public, appointed by the Governor in a manner that ensures geographically diverse membership, including:

(A) nine or fewer members who are Deaf, Hard of Hearing, or DeafBlind provided each population is represented and that if a member represents an organization for persons who are Deaf, Hard of Hearing, or DeafBlind no other member on the Advisory Council shall also represent that organization;

(B) two members who are each a parent or guardian of a child who is Deaf, Hard of Hearing, or DeafBlind;

(C) two members who serve persons who are Deaf, Hard of Hearing, or DeafBlind in a professional capacity, provided that these members do not represent the same organization;

(D) a professional deaf-education specialist who understands all communication and language modes;

(E) a professional interpreter; and

(F) an audiologist or hard-of-hearing education specialist;

(2) the Senior Counselor for the Deaf and Hard of Hearing in the Department's Division of Vocational Rehabilitation or designee;

(3) the Secretary of Education or designee;

(4) the Secretary of Human Services or designee;

(5) the director of the Department for Children and Families' Children's Integrated Services or designee;
(6) the director of the Vermont Early Detection and Intervention Project;
(7) a representative of the Vermont Association of the Deaf;
(8) a superintendent, selected by the Vermont Superintendents Association; and
(9) a special education administrator, selected by the Vermont Council of Special Education Administrators.

(c) Powers and duties.
(1) The Advisory Council shall assess the services, resources, and opportunities available to children in the State who are Deaf, Hard of Hearing, or DeafBlind. It may consider and make recommendations to the General Assembly and the Governor on the following:
(A) the educational rights of children who are Deaf, Hard of Hearing, or DeafBlind, including full communication and language access in all educational environments and accessibility of qualified teachers, interpreters, and paraprofessionals;
(B) appropriate and ongoing educational opportunities that recognize each child's unique learning needs, including access to a sufficient number of communication or language mode peers and exposure to adult role models who are Deaf, Hard of Hearing, or DeafBlind;
(C) adequate family supports that promote both early development of communication skills and informed participation by parents and guardians in the education of their children;
(D) identification of all losses of or reductions in services arising from the closures of the Austine School for the Deaf and the Vermont Center for the Deaf and Hard of Hearing and evaluation of the adequacy of existing services and resources, as well as identification of those resources not currently available, adequate, or accessible to children;
(E) opportunities to restore and expand educational opportunities to children in the State who are Deaf, Hard of Hearing, or DeafBlind and their families; and
(F) appropriate data collection and reporting requirements concerning students with disabilities.
(2) The Advisory Council shall assess the services, resources, and opportunities available to adults and elders in the State who are Deaf, Hard of Hearing, or DeafBlind. It may consider and make recommendations to the General Assembly and the Governor on the following:
(A) the needs of and opportunities for adults and elders within the State who are Deaf, Hard of Hearing, or DeafBlind and their families;
(B) the adequacy and systemic coordination of existing services and resources for adults and elders throughout the State who are Deaf, Hard of Hearing, or DeafBlind and their families;
(C) proposed legislation and administrative rules pertaining to adults and elders who are Deaf, Hard of Hearing, or DeafBlind; and
(D) delivery models in other states as a point of comparison for the adequacy and systemic coordination of Vermont's existing services and resources for adults and elders who are Deaf, Hard of Hearing, or DeafBlind.
(d) Assistance. The Advisory Council shall have the administrative, technical, and legal assistance of the Agencies of Education and of Human Services. The Advisory Council and Department may consult with national experts on education of persons who are Deaf, Hard of Hearing, or DeafBlind as necessary to fulfill their obligations under this section.

Bill will provide a list of current members and their bios. All positions have been filled except for one slot. They have been working with a person from a school in Massachusetts and are hoping she will be able to join on a permanent basis.

Bill shared that this was his first time working with the Legislator process. He felt the experience was positive and that the D/HH/DB population gained a tremendous amount of support from the legislature this session. The Vermont Association of the Deaf put a lot of effort and time into supporting and moving this S66 bill along as well.

III. Board Updates
DAIL Advisory Board members

Robert Borden informed the Board that his future participation may need to change. He may need surgery for a herniated disk. He will not be able to attend the July meeting and Beth Stern volunteered to be his back up. He will keep us posted on this situation.

Governor Shumlin has declared June 7th to be "Vermont Gives" Day of Giving, our state's first-ever 24-hour online fundraising event by Vermonters, for Vermonters. Gini shared the amount the COVE received. Beth Stern announced that CVCOA received an anonymous donation of $10,000. The donation did not come through the Day of Giving website, but did come at the same time. She was not sure if it was prompted by this fundraising event or not. But, it was a very great surprise.

IV. Personnel Updates
Camille George, Deputy Commissioner DAIL

Bard Hill will be coming in for the afternoon to cover for Camille. She was called into an important meeting this afternoon. Monica Hutt is on vacation and will be returning June 27, 2016. Dick Laverty is retiring on June 30th. Dick has been the "heart and soul" for our SAMS software and will be greatly missed. Dave Yacovone, who was brought in to do work with the Older Americans Act (OAA). His last day is June 24th and he is off on a new path of running for State Representative. Patrick Flood is running as well. Either one will represent the aging population well. Currently working on Dick's and Dave's replacements and will announce more soon. The Division of Vocational Rehabilitation (VR) is very close to hiring a new VR Regional Manager that who will be based out of the Barre VR Office. The Division of Adult Protective Services is looking for someone to oversee the intake process.

The Governor's Commission on Successful Aging is sun setting. The subcommittees – Workforce, Health Care and Livable Communities – have had representatives from DAIL, the Department of Mental Health, the Vermont Department of Health and the Department of Health Access. The Workforce Committee may continue to meet – updates to come at a future meeting.

V. **Suicide Prevention**
Jaskanwar Batra, Medical Director, Department of Mental Health

Jaskanwar (J) Batra began his presentation with a short history of how he became involved in Suicide Prevention of elders. His residency at the University of Vermont in the field of geriatrics. He then went to work at the Adirondack Medical Center where he continues to go on a monthly basis to keep up his clinical work.
Human beings have an innate desire to survive in the face of threat. We have a fight or flight instinct that assists in this survival. This desire to survive is nothing we have to think about as it is instinctive. If the desire to survive is instinctual, why did 43,000 people in this country die by suicide last year? This number of deaths is alarming, yet there it is not being looked at as closely as other types of death or threat of death. For example, there has been one death due to the Zika virus and it is all over the national news. Yet, thousand die by suicide and it isn't even on the federal government's radar.

Vermont is the 7th highest state in terms of people who die by suicide. And we are increasing at a higher rate than the rest of the country and our aging population is surpassing the national average. The hope is to partner together to do something about this. Thomas Joiner's model of interpersonal theory of suicide shows the three circles of influence that can lead to suicide – Lack of Belongingness ("I am alone"), Perceived Burdensomeness ("I am a burden to my family/friends/etc."), and Capability for Suicide ("I am not afraid to die"). When these circles of influence start to emerge the possibility of suicide increases. What is going on for these circles to emerge? Mental health issues and substance abuse are the highest reasons. The graph labeled "Risk Factors Preceding Suicide" illustrates other reasons such as partner/relationship problems, financial, health, family and criminal. The graph also shows the rates by male and female and how they can vary. Other studies show that having a family member that has died by suicide can increase chances, as well. Rural areas have a higher percentage of death by suicide than urban areas – this contributes to isolation and feeling of being alone. Another chart that was presented shows who died by suicide and were they getting services. It was noted that only those getting services at Vermont's Designated agencies were included in that data. From national studies we know that many, approximately 70%, had reached out to their primary care physicians (PCP). But, unfortunately, not all PCP's are trained in suicide prevention.

The presentation then turned to some interesting facts surrounding death by suicide. Garrett Lee Smith Grant was the first funding source for suicide prevention. Garrett Lee Smith was the son of Senator Gordon Smith. After his son's death, he advocated for a way to support the prevention of death by suicide. Projects such a U Matter and the Gun Shop Project provide awareness and outreach to suicide prevention. The most common way people die by suicide is with firearms. And it is not just men that use this method, it is on the increase for women as well. The Gun Shop Project was started when 3 people in a small town in New Hampshire went to the same gun shop, purchased firearms and died by suicide in the same weekend. The owner of the shop was devastated – What could he have done to prevent this? What signs did he miss? The goal of the project is to provide educational material to gun shop owners – what to look for, how to refer to services. As of January 2016, the material has been distributed. This fall, members of the project will go out to see if the material is still out there and conduct a second round of interviews.

It is typical to think of suicide is a choice. We also tend to equate suicide with depression. But is it really a choice? Try thinking of it as having no other option. When a person is holding on to a bar, swinging by their arms, after a while, they just can't hold on anymore. They let go of the bar. It is that choice or is it that you no longer have the strength to hold on to that bar? So is suicide an act of free will or is it an illness that should be looked at as a medical model? Now there is a suicide focus care using suicide focus training. When clinicians treat for depression and for suicide the success rates improve. Treatment for depression is cognitive therapy – how you think, feel, what you do. Suicide focus treatment is the unraveling the suicidal thoughts – unlinking the thoughts of being a burden, etc.

With all of this information, data and experiences, why Zero Suicide? This is a national model that is being adapted to use in Vermont. It is largely based on Air Force Suicide Prevention that was developed in the 1990's. The Henry Ford Health System (HFHS) showed us that when we improve the quality of care for patients that came in for services for depression. They found that when they treated the depression, deaths by suicide decreased. HFHS actually had zero suicides – not every year, but some years it achieved it. HFHS is a model of an integrated health care system. The screening process has a much broader concept. You cannot just look for depression. You have to know how to look for hopelessness, too. People, like many of our providers, come in contact with a large number of people. They are in the position to do screening and can be involved. Another key aspect of suicide prevention is follow-up after acute care services. It is usually one or two questions. How are you? What do you need? Using methods to tell a person that you care, suicides go down – a letter, a postcard, an email.

Vermont is launching Zero suicide pilot. There are pilot sites in Franklin/Grand Isle and Chittenden counties. Staff are being trained in suicide focus, or gatekeeper training. To achieve Zero Suicide, we need to collaborate with anyone that works with people seeking care in health centers. This is a greater initiative than AHS alone.

A Suicide Prevention Coalition has been created that includes members from all six departments within AHS, The Center for Health and Learning and a host of others:

- Center for Health & Learning
- University of Vermont
- Vermont Department of Health
- Department of Mental Health
- Department of Disabilities aging and Independent Living
- Veterans Administration/National Guard
- Suicide survivors (Family + attempt)
- Higher education institutions
- Schools
- Agency of Education
- Office of Rural Health
- Department of Corrections
- Legislators
- American Foundation for Suicide Prevention
- Designated Agencies
- Support and Services at Home (SASH)

With AHS and all these community partners, we strive towards Zero Suicide.

VI. America's Health Rankings – Senior Report for 2016

Bard Hill, Director of PPAU, DAIL

The United Health Foundation released their 2016 America's Health Rankings Senior Report. Vermont was ranked #2 in the United States for overall health behind Massachusetts. Two of Vermont's strengths are low prevalence of smoking and high SNAP enrollment. A few deficits are low hospice care use, high prevalence of drinking and high prevalence of falls.

There was much discussion over Vermont's rankings. Food insecurity was higher than expected since SNAP enrollment was high as was Home Delivered Meals. Vermont ranked 47th in Hospice care. This includes in-home and residential Medicare hospice care.

Several topics from the report were identified to need further discussion. The Board identified areas that will be agenda items for future DAIL Advisory Board meetings.

Meeting was adjourned