GuideLink Center Advisory Board Meeting Notes

January 11, 2022

1. **Call to Order:** 10:04am
2. **Attendance:**

Cindy Hewett	Dustin Liston	Brad Kunkel
Michelle De La Riva	Sarah Nelson	Tess Judge Ellis
Crissy Canganelli	Denise Brotherton	Leslie Carpenter
Diane Brecht	Louise From	Matthew Miller
Shane Kron	Michael Flaum	Ryan Heiar
Monika Jindal	Jackie Smith-Duggan	Diane Venenga
Mark Bullock	Lance Clemsen	Fiona Johnson
John Grier	Abbey Ferenzi	Ashley Salinas
Jan Shaw	Lisa Green-Douglass	

3. **Public Comments for Items Not on the Agenda:** None
4. **Executive Director Report**
    a. **Data Summary (see PowerPoint)**
    b. **Questions/Comments from Advisory Board Members and Response Summaries**
        i. ***How does helping the person access care after they leave services at GuideLink Center look?***
            1. *In the past, it has been a phone call to services outside to help set up appointments and some client follow-up, but now with a new position in place, it will be more than that. It can be accompanying clients to appointments, providing one-on-one direct collaborations to pinpoint services etc. and additional focus to care coordination and follow-up to improve outcomes and engagement. Plus since this is a peer position, this individual can offer their lived experience to help individuals address their needs and navigate the system.*
        ii. ***How do you determine when the care is being followed through?***
            1. *Tracking appointments kept, engagement in services and outcomes, but it is important to have the correct infrastructure in place to plan and track this. Our goal is to be more proactive with someone's follow up, promote recovery and prevent crisis relapse.*
        iii. ***There are surprisingly a low number of jail referrals which is strange when hearing about the number of those incarcerated with mental health disorders?***
            1. *We have gotten some jail referrals but these individuals typically have high and complex needs and often go to the ER. Individuals who end up in jail are typically fit into the "complex needs" category and the ability to be served has been challenging for*

providers. We are open to referrals from the jail and have worked with jail alternative counselors in the past.

iv. ***Do we have any thoughts why the two months on the graph [Law Enforcement Dispatches Graph] are higher?***
    1. *Weather can play a factor (transition from one season to the other displaces a lot of individuals), students returning, holidays and intensity of situations increase due to the holidays and particular clients that require the intervention of law enforcement.*

v. ***What is the difference between someone presenting as intoxicated and someone needing withdrawal and how is it decided where they go?***
    1. *When someone is acutely intoxicated, they go to the sobering unit. However, once their presentation starts moving into a withdrawal state, that is where we will start to shift the plan of treatment. This is for the sake of giving them the correct type of intervention such as detox vs sobering. Many present significantly intoxicated and are not ready for detox or did not meet criteria but as they stay in sobering longer. Not everyone that is intoxicated will go through withdrawal (med detox is mainly for alcohol, opiates and benzodiazepines) and staff can usually pin point these individuals based off of assessments. Outcomes have improved since both a sobering unit and med detox unit are available.*

vi. ***When looking at diversion, what entails "inadequate care"?***
    1. *Inadequate care for both law enforcement and individual report usually indicates that they did not have plans to treat their crisis, the plans they had were not sufficient, or because they did not fit the ER or jail option, they are left without options to consider. Inadequate care can lead to exacerbated crisis conditions and poor outcomes.*

vii. ***Denials and temporary holds on services: It should be noted that "history of behaviors" does not necessarily bar someone from admission into our services. There is a policy in place that requires a process and a number of reviews and thorough discussions before someone has a pause on services. These individuals and incident reports are reviewed weekly at manager meetings. This decision is usually in result of a severe case in which people were at risk of danger, but we always work towards being able to serve as many individuals as we can with safety considerations in mind.***

viii. ***When stating a "bed is full" is it because all beds are being used? Aren't there 16 in the facility? Under the assumption that beds are flexible and not designated to one service, how are we not moving a bed when needed?***
    1. *"beds full" is also an indication that beds are at capacity based on what staff can provide. Staff ratio is a big consideration when discussing bed placement beyond the 4 that are open in crisis stabilization. There can be a change in phrasing that would indicate the true meaning. We can start referring to it as "at capacity".*
    2. *It should be noted that Diane Brecht is working with DHS to modify Iowa Code to decrease the barriers in hiring staff which could in turn help bring ratio up and increase the bed capacity.*

ix. ***What happens to people who do not have a bed to be placed in?***

1. *Those who aren't placed are spending extra time with counselors to make a safe and thorough plan and find resources and referrals that can assist them after leaving.*

x. ***Besides additional staff, we need staff who are skilled in crisis de-escalation. When discussing complex needs and behaviors, a lot of the outcomes depend on the skill level of staff which means stake holders and the board must know we cannot continue to pay entry level wages for those who need professional level intervention skills.***

Year-End Summary:

c. **Collaboration:**
   i. Internally: This is going well! It takes a lot of work and a lot of effort—ups and downs but efforts are worth it and the support and collaboration is helpful for both staff and clients.
   ii. Externally: This extends out to local agencies which continue to meet with GuideLink Center. GuideLink Center takes part in several meetings locally and discussions across the state and even the country that share the experiences and challenges to other facilities similar to GuideLink.

d. **Community Awareness:**
   i. Abbey has and continues to do a lot of presentations and attend community events. There are flyers and brochures out in various partners offices.

e. **Systemic Impact**
   i. GuideLink Center continues to try and have an impact the mental health/substance use care and healthcare system. Working towards positive outcomes and collaboration; the "ripple affect" throughout the system.

f. **Marketing**:
   i. There are continuous meetings that discuss the strategies for reaching the needed audience and that can work to explain exactly what GuideLink Center is and how it can help. Recently contracted with DeNovo and have a planning meeting with them today.

g. **Projected Growth:**
   i. Opening and expanding services during a national staffing shortage and pandemic has been challenging, but we continue to work on plans to sustain current services and expand capacity.

h. **Lessons Learned:**
   i. Program needs have become noted over the course of operating this year. The need for additional clinical and care coordination staff is apparent. The data has been gathered and we have tracked outcomes and will continue to collaborate on how to address these needs.

Current Programming:

i. **Updates:**
   i. CommUnity Crisis Services & Food Bank continues to work on hiring additional staff for Triage. The need has been identified on second shift as it

is and the busiest times and with the anticipated increase of walk ins, there will probably need to be two Triage Counselors on every shift.

ii. Abbe Mental Health Center and Penn Center have merged and are one company known as Abbe Mental Health Center.

iii. Crisis Observation continues to be a challenge to staff specifically nurses. There is talk to help modify the set up and hiring requirements with DHS. There is a lot of thoughts to see how we can address the staff shortages from all sides of GuideLink Center. It is important to note, that staff should feel supported and valued in many ways and there needs to be work towards this.

5. **Advisory Board Meeting Dates**
    a. There will be a pole for new dates and possibly times/lengths going out soon.
6. **Advisory Board Recommendations**
    a. **Security at GuideLink Center**
        i. In operating a 24 hour Access Center and working with those in Crisis in order to make sure we can serve clients and operate safely, there has been a recommendation to implement security.
            1. **Lisa Green-Douglas:** How can we make this a possibility while maintaining the welcoming environment the original team of people envisioned?
            2. **Leslie Carpenter:** It is wonderful to not have that need and have a therapeutic and welcoming feeling, but it can still be maintained if we work on hiring the *right* person. I was surprised that there is not security at GuideLink Center. Even those in crisis who show psychotic symptoms, disorganized thinking will still be able to recognize the image and function of security.
            3. **Brad Kunkel:** CIS training is still happening for officers. This discussion of security is interesting and complex. On one hand you don't want them to look like police while on the other you still want them to function and keep safety a priority. Questions come into play such as to what extent do you want them to intervene? What are boundaries that are going to be put in place for them? It is a really tricky conversation to have.
            4. **Sarah Nelson:** It is important to consider that we are making this decision while not being fully staffed. Aggression on that level happens when we don't have the right skill levels interacting with them. It is important that we recognize this experience has to be therapeutic and not traumatic. For one client it might be effective to see an authority figure but for another it might be triggering which means we have to have the right staff that can recognize these dynamics and know which response to go through with. (Such as calling security or triaging them). An un-uniformed security guard who is trauma informed and CIS trained is the best route. We have to be very very careful on how this security entity will be designed and make sure it doesn't become a stand in for triage staff. We would need to make sure that staff understands they still have to use their skills to de-escalate and help rather than default to security.

5. **Michelle De La Riva:** Prelude has never had security and it was rare that we ever had law enforcement intervene. Adequate screening and interventions are helpful to prevent safety issues.
6. **Abbey Ferenzi:** The idea is to have an individual who is not uniformed and will not be walking around the client area. They would be stationed in one area and would do perimeter checks. This intermediate level of response can help prevent the armed and uniformed LE from coming into the unit—that is happening now when we have to call the police. This causes more tension and trauma for staff and clients than a security guard would. This person would not respond to client area unless it was specifically requested. Training, approach and utilization would all be carefully considered, Ultimately, this would have to be a pilot program to see how it works and then reassess if it doesn't work.
7. **Monika Jindal:** With the current workforce shortage and the running of GuideLink Center at the moment, the ration on an overnight seems concerning. It is sometimes 4 staff to 12-15 people and for some staff that is not comforting.
8. **Abbey Ferenzi:** Sounds like most are in favor with careful considerations. We want to ensure that it doesn't impact the environment of the patients and doesn't prevent staff from utilizing their skills and default to security when someone escalates. The goal is to make staff feel safe, make clients feel safe and ultimately not have as much police presence in the client area.

b. **Additional Safety and Medical Equipment:**
   i. Regarding Sobering; paramedics and staff working on the sobering unit have stated that the mattresses on the floor can be concern of safety. They have witnessed a number of intoxicated individuals throwing themselves on the mattress and nearly missing it and hitting the floor. This becomes a risk and when talking about this it leads into other conversations that can be had in order to improve the safety and accessibility of GuideLink Center.
      1. Call Systems provides an extra layer of protection and connection to staff and medical beds help alleviate discomfort of detox beds experiencing certain symptoms.
   ii. **Lisa Green-Douglass:** What needs to be done is having a discussion at this Advisory Board meeting that Abbey can present to the Supervisor's Board. Starting with a question of what could be the minimum number of beds?
   iii. **Michelle De La Riva:** Detox is a medical program and so often people need more from the equipment that is already given. Medical beds can help with the comfortability of a patient who needs special needs met due to their medical needs from detoxing. The call system is a way to alert staff/nurses of an accident when the physical demands make it harder otherwise.
   iv. **Monika Jindal:** Having medical beds with railing is safer from a symptomatic standpoint, but it also gives more flexibility to better serve some individuals who have extra physical needs met. It might not have to be in every single room, but it can be in a number of rooms.

v. **Diane Brecht:** Perhaps, there needs to be a subcommittee to talk through this and look at the floor plan and be able to make this decision follow by other changes that might need to be made.
vi. **Sarah Nelson:** A subcommittee is helpful right now anyways to see what is needed after a year of operation. Where do we see it going etc… and talk about what can GuideLink Center do? Also, insure we are looking at the right issues and solving the ones that need to be solved.
vii. **Lisa Green-Douglass:** What is the minimum number of beds?
viii. **Diane Brecht:** 4-6 beds would be helpful
ix. **Matt Miller:** If it is coming down to patient safety—we should do it. If we have a budget to do it, we should do it.
x. **Abbey Ferenzi:** It looks like there is no significant opposition to this. It is a great idea for a subcommittee to be made and we will be looking into forming one of those. We will be presenting to the Board of Supervisors today on the topics discussed.

c. **Crisis Respite:**
i. **Sarah Nelson:** When looking at some of the gaps and how we can support different people and entities, the space where Mobile Crisis Office is located is not required which would open up a space to help support those who are in crisis but with lower barriers. It is a space for someone to get respite. It wouldn't be appropriate for everyone, but it could help a handful of people similar to those we had to turn away. It is being done in other places right now.
ii. **Lisa Green-Douglass:** Where would Mobile Crisis go?
iii. **Sarah Nelson:** Due to the move of the Food Pantry, the location is vacant for MCO to take up.
iv. **Jan Shaw:** Is this a Medicaid funded services? The Iowa Code requires observation which this would not be able to replace and meet the needs of.
v. **Abbey Ferenzi:** There are individuals who could not process the intake process for Crisis Stabilization or Crisis Observation; that is clear after the first year of operating. . This Crisis Respite is not intended to replace Crisis Observation at all and the intention to get it up and going is still a strong effort. However, in the meantime we still have to turn people away and Sarah's proposal is a way to meet the needs of these individuals and the needs of the local agencies including law enforcement.
vi. **Monika Jindal:** The way to wrap the your mind around it is this: A lot of people come in that struggle to meet program requirements and we need a service that can lower that barrier significantly to help those individuals. Iowa Code makes it hard for those individuals to engage, but this can be a gateway into further services.
vii. **Diane Brecht:** This sounds like a great pitch for a pilot program to manage care companies.
viii. **Abbey Ferenzi:** There are many layers of the crisis care continuum and this is one of those that is actually already being done in other states. This is also a way to help prepare for the increase of individuals that come through our marketing campaign and as more people learn about GuideLink Center. The concern seems to come about due to funding which understandable. The idea

of all of this is to help the decrease the rate we turn away individuals, increase their likelihood to engage and present solutions for the many challenges we face.

7. **Adjournment:** 11:57am