Vermont Action Plan for Aging Well Advisory Committee
Meeting Minutes

Date: **December 19, 2022**
Time: 10:00AM – 12:00PM
Location: Virtually on MS Teams

Members Present (alphabetical): Janis Appel, Ruby Baker, Anna Benvenuto, Lynne Cardozo, Eliza Eager, Kim Fitzgerald, Eric Fritz, Mary Hayden, Elaine Haytko, Jake Hemmerick, Helen Labun, Mark Levine, Maggie Lewis, Dan Noyes, Janet Nunziata, Jill Olsen, Jason Pelopida, Meg Polyte, Symphorien Sikyala, Julie Skarha, Gregory Smith, Kelly Stoddard Poor.
Planning Team Present: Angela Smith-Dieng, Kerstin Hanson, Megan Tierney-Ward
Presenters Present: Kaley Phillips, Intern

MINUTES:

Topic	Notes	Action
Welcome, Introductions and Announcements	• Ruby – The 2nd edition of the COVE Resource Guide on Aging in Vermont is printed - a comprehensive guide for older adults in VT and their family caregivers w resources & info based on the principles we have been working on here. Also has a directory; 120 pages total. Co-sponsored by UVM Center on Aging and VT Kin as Parents, DAIL. Will be online soon. https://www.vermontelders.org/vtresourceguide • Helen Labun – joining the group taking over for Laura Pelosi for VT Health Care Association • Jason Pelopida – new State Unit on Aging Director in Adult Services Division; background w meals on wheels & personal care management field in Bristol, MA • Angela - this has been a learning year of reviewing the Older Vermonters Act principles and how systems work in VT. Also did the Age Friendly EnVision VT survey, then listening sessions in November. ○ Listening Sessions: 5 in-person, 1 virtual w questions related to the OAA principles resulted in rich conversations and 70 pages of notes. Will pull key themes & take-aways for summary document to share at next meeting in 2023. ○ Focus Groups: targeted populations and groups to ensure we hear from a diverse group of Vermonters. Goal is for February sessions w results in April 2023.	*If interested in being further involved, particularly in the communications plan, reach out to Angela or Kerstin.* *January – March advertising is good time in VT; consider Across the Fence in January* *Podcast collection: https://www.vtfoodinhealth.net/podcast-collection (and would recommend the series on how our perception of flavor changes as we age, in Season 4)*

	○ Surveys: One page data brief via Julie Skarha compares online vs paper survey results. Note that missing responses resulted in no strong conclusions or comparisons. ○ VT State Center Data Brief: Census data related to older Vermonters 2011 vs 2021. Aging population is rising. Good info on other things such as housing, income, etc. ○ MPA Collaborative: Monthly TA calls with national partners & other states for good ideas & opportunities. Working with the Windham Senior Health Collaborative to apply for funding offered for a strong communications plan. • Q&A: communication plan – consider Across the Fence in January; good months for advertising in VT are January – March	
Presentation & Discussion: Q&A	Community Health Needs Assessment Data Presentation by Kaley Phillips, Intern • Research around the 14 Community Health Needs Assessments the hospitals do around Vermont. • Transportation – availability vs. knowledge of options & eligibility; want to know barriers & challenges for follow-up. VPTA Link: https://www.vpta.net • Mental Health – diagnosed condition vs. grief/isolation. What mental health issues are/are not addressed? • Data does not prioritize needs. • Demographics: majority of respondents are white, highly educated women	*See presentation slides attached* *CHNAs available here:* Individual Hospital Documents | Green Mountain Care Board (vermont.gov) • We have an interview with Gifford on how they use the CHNA https://www.plainerenglish.org/866545/2700730-community-health-needs-assessments *Send any follow up questions to Kerstin*
Main Topic	Coordinated System of Services with Angela Smith-Dieng Breakout Group Discussion Sessions: 3 groups Summarized report-outs: 1. What is working well? *Movers:* There are multiple opportunities if you can get to them. People engaging in the system are thoughtful & care about doing good work & showing up, engaging, etc. Specific areas of growth with certain models working well, ex. SASH, Home Share, some primary care & long-term care systems.	*See presentation slides attached*

	Shakers: Once people know that there are services & they exist and can come into the system, then we have a menu of options and variety of services. Getting connected can be a challenge. Community Health & Care Coordinators are important at the local level to connect folks to resources. *Creatives:* Our state is very adept at establishing policy objectives, goals & agreements in a broad way that is better than other states. For example, cross-border collaborative of services, VT is providing a higher level of service than a bordering state would be. EMS in particular is highly responsive. Aging in place/at home initiatives filling gaps from official systems. Telehealth flexibilities being helpful in our system. For those w family who can support them, we have many options in our system. Services tend to work well. Waivers available to long-term care facilities through pandemic as dealing with workforce. 2. What are the gaps? *Movers:* Vermonters have a fierce independence and want to find our own resolutions, resulting in a lack of consistent experience. There are 4,700 non-profits in VT – a huge amount of money spent on overhead across our systems that in some ways stunts our ability to provide the high-quality consistent experience to people regardless of where they live. We are a small state, so hard to balance in-state vs out-of-state access to services. Housing – workforce shortage because no place for them to live, also long waitlists for those trying to move into senior, low income, assisted living, nursing homes, etc.; may have beds but due to workforce shortages so not available. There are folks literally living for months in hospitals at much higher expense because they can't get into housing. The reimbursement rates don't cover the cost of the beds. Transportation challenges, particularly in remote areas and other areas where they don't drive. To engage in the richness of our communities, unable to do so due to no transportation. Discharge planning, care coordination, transitions of care across regions from one situation to another consistent with care needs is tricky. Started to talk re: populations missing from our thinking – we now have folks w developmental disabilities living into older age and we haven't talked about that. And many other populations.	

	Shakers: growing mental health needs and high suicide rate among older adults & gaps in services. We have no public guardianship option for folks under 60 if don't have a developmental disability. Importance of getting assistance before there is a crisis point. Many don't know about services or if qualify for Medicaid, etc. challenge of enough case management for folks w dementia and caregivers, given complexity of what they are dealing with. Younger onset of Alzheimer's may not be eligible for all services. Disconnect between social and clinical services. Workforce crisis is a big challenge for systems. Funding, financial stability connected to staffing. Transportation services are there but challenges in prioritizing, etc. lack of volunteers leads to trips being cancelled. Lack of geriatricians, housing stocks, etc. accessibility for both new and existing – money for home modification for aging in place. All issues are critical at transitions of care. Aging is a series of transitions and people don't want to talk about it or make a plan for it. We need to better prepare individuals and our systems to make transitions more successful for everyone. Cultural barriers- lack of value on workforce, ageism built into our system, long term care facility beds, etc. *Creatives:* focused on overarching themes in health care system; financial pressures and how solutions are creating expenses, ex. traveling nurses which doesn't justify itself in revenue generation. Generally, we are in a crisis situation in workforce, etc. creates another issue w healthcare system and home and community system unable to discharge folks to receive services at home, for example. EMS services also experiencing not being able to recoup cost of services. Caregivers and population w Alzheimer's and dementia related disorders – overall societal disposition or attitudes and even understanding that people have the right to live where they want to and the people in the system who provide services understand that. Even in the healthcare sector folks may not understand that and not just in residential situations. Need to educate. Also not really understanding (cultural issue) that people do want to age in place (at home and/or community) and the attitude is not embedded in the health care community. Also discussed challenges for direct care service workforce and as a society not respecting or valuing the skill and	*Notes will be put together to start to flesh out goals, action plans & strategies to inform next steps for change/improvements in our system of care.* *If you are interested in being more involved, please reach out to Angela or Kerstin.*

	knowledge that it takes to do that work and that prevents people from pursuing that career trajectory and sort of another cultural barrier we need to overcome – for respect & pay and understanding. Not just supporting physical needs. Also, cognitive & mental health. Housing impact on older population – lack of availability – long waiting lists for older people.	*Send any follow up questions to Angela*
Meeting Schedule	**Next Meeting: Monday, February 27, 2023,** 10:00AM – 12:00PM via Microsoft Teams. Reminder, you can find minutes/materials from meetings here: • 2021: Vermont Action Plan for Aging Well Advisory Committee | Disabilities, Aging and Independent Living • 2022: Vermont action Plan for Aging Well Advisory Committee 2022 Meeting Agendas and Minutes	

Questions/edits re: these minutes, please contact Kerstin.hanson@vermont.gov.