Upper Valley Health Priorities
Legislative Breakfast Discussion Notes

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I. Substance Misuse & Addiction

Subject Matter Expert: Melanie Sheehan (Director of Community Health Outreach at Mt. Ascutney Hospital)
Facilitator: Angie LeDuc (Senior Community Partnership Coordinator at Dartmouth Hitchcock)

Major Themes:

1. 1 to 1 interventions vs. broader level environmental policies
a. Need to balance the efficacy of a 1 to 1 intervention with its cost on the public.
2. How do we transition people from Corrections back into communities?
3. Need for policies that aim to alleviate trauma and prevention (early stages) versus solely treatment
4. Access at different levels – decreasing at prison level, in community, in the home, parental norms
5. How can we best invest in prevention so that the cycle of substance misuse isn't repeated and we spend less on treatment down the line?
6. Alcohol is the most used drug and also tends to be the gateway to other drugs and lifetime addictions
7. Build infrastructure BEFORE laws are passed
8. Confusion about CBD - being used as a cure all and marketed towards all ages but no research about positive and negative long-term consequences

Remaining Questions:

1. How do we balance protecting the community but keeping lower level users/dealers out of jail?
2. How do we address employment barriers for individuals recently released from prison/jail?
3. How do we balance needs of individuals in treatment and recovery and also get upstream in prevention?
4. NH – what will happen relative to legalization of recreational marijuana?
5. How are we going to test, regulate, educate, and enforce after legalization; limit THC level in edibles?

Round 1 Notes:

Discussion Table Members: Carl Demrow (VT), Alice Nitka (VT), Mike Cryans (NH), Brian Sullivan (NH)

Recent Successes:

1. Tobacco purchase age raised to 21 (VT)
2. Banning billboards (VT)
3. Taxing e-cigs (VT)
4. Banning vaping in schools (NH)

What Questions Did People Have Before the Discussion?

1. Public health concerns of vaping
2. Tobacco 21: we don't know the effects yet, but it is definitely best practice and known to be effective.

Discussion Points:

1. Effect of small states can be very large and broad
2. Effects on families – stress, trauma, Adverse Childhood Experiences (ACEs), kinship care, etc.
3. Methamphetamines on the rise again – how do we address this in the general population? How will we be addressing this in jails?
4. Consider how longer-term use and addiction develops – most young people start using alcohol, followed by marijuana (NH)
    a. Prevention and awareness should be prioritized
    b. Rising instances of parents approving CBD products, this is dangerous and needs to be managed.
    c. Data is supporting investment in early childhood – social emotional learning curriculums, trauma informed care, support and education for educators and caretakers, etc.
    d. Inabilities to read and other delays can impact drug use later in life

    e. Social connections are very important
5. Opiate Death Summit
    a. VT has no possession with intent to distribute law (specific drugs?)
    b. Trails Program in Sullivan; Grafton Drug Court Program; Diversion; need more of these options for offenders
    c. Trails provides life skills, recovery skills
    d. Sober house to open in Claremont for individuals recently released from Sullivan Corrections
    e. Medicated Assisted Treatment (MATs) has limited availability among prison/jails in NH
6. VT – unified corrections system
    a. 6 facilities/prisons around the state that have detainees and sentenced
    b. Cost effective, but still costs $16,000 per inmate
        i. Many individuals outwardly voice they don't want to leave jail because they will end up right where they started
        ii. VT is working with individuals who are ready to get out who are able to have a license and get all the documents necessary for them
        iii. Is there an opportunity for NH here to coordinate?
    c. 1 to 1 interventions—effective but costly
        i. Public policy has a greater effect on the public
        ii. Downstream interventions are getting more funding in the last couple of years, consider environmental policies - access in home, community, etc.

Round 2 Notes:

Discussion Table Members: Jim Harrison (VT), Mary Jane Mulligan (NH), Charlie Kimbell (VT), Ned Gordon (NH), Susan Almy (NH), Paul Manganiello (Medical Director, Good Neighbor Health Clinic)

Discussion Points:

1. NH has done good job with medical marijuana in terms of branding, marketing, etc.
2. 5% tax on alcohol that was meant to be for prevention was diverted to therapy or not allocated for substance misuse at all.
3. $40 million to treatment, but prevention is lacking
4. CBD industry
    a. VT – legal but not regulated; THC can be higher than "approved" levels
    b. Prevention lens: parents giving to kids for XYZ reason (claims for all health issues)
5. Vaping
    a. NH – How do we get enough money out of it to be able to do regulation that should be getting done already ; $6 tobacco license for retailers and FDA grant to see how many sold
    b. NH Smoke shops – no regulations, dangers in what they're selling
    c. NH school vaping ban – addressing nicotine addictions and the negligence surrounding the use of nicotine products
    d. Is progress being made on substance use disorders?
6. VT – environmental policies have been successful for tobacco reduction; no billboard marijuana marketing, we need to look at THC limits (public using upwards of 80% THC level, but government can only study 12% levels);
7. NH – banning vaping in schools, 5% tax on alcohol
8. Internet ordering via VT growers
9. Not enforceable because the infrastructure was not done before legalizing

II. Access to Mental Health Care Services and Supports

Subject Matter Experts: Susan Seidler (Director of the Stepping Stone and Next Step Peer Support), Kate Lamphere (Adult Services Division Director)
Facilitator: Heather Wilcoxon (Area Manager for Children, Youth and Families at Health Care Rehabilitation Services of Southeastern Vermont)

Major Themes:

1. Licensure reciprocity between NH and VT needs to be pursued.
2. Attraction and retention of high- quality mental health professionals required to serve the level of acuity/complexity/dual diagnoses of the population, whether through loan forgiveness (which can still lead to attrition) or simply pay parity with competitors.
3. VT allows peer supports (non-clinician specialist counselors) in clinical encounters (ED particularly), NH does not consistently. Peer supports can avert inpatient hospitalization and improve long-term outcomes (per the experts at the table). There is an opportunity for guidance from VT in accepting this critical piece of mental health care.
4. There is a 'logjam' of beds. There is a lack of transitional housing, so people are staying in acute care rather than be discharged to homelessness. There may be a need for acute care beds, but it is not as great as the need to find safe places for people to go when they are done with the beds. A striking quote from one of the experts today "I have plenty of housing vouchers for these people, but no PHYSICAL PLACE to discharge them TO."
5. Credentialing is also an issue because there is no reciprocity**.** Needs to be worked on. Should work on having a way to hire people from VT temporarily while they are being credentialed

Round 1 Notes:

Discussion Table Members: Michael Kiess (Vital Communities, Workforce Housing Coordinator), Martha Hennessy (VT), Jim Harrison (VT)

Discussion Points:

1. Pay Parity
    a. Level of loan forgiveness, loan repayment
        i. Clinicians are so enthusiastic about serving the population but cannot afford debt payments at such a low salary
2. Housing: hospital diversion or stepdown; this past year Kate Lamphere said she saw half the normal number of admissions over the past year. People are stuck in the beds – people cannot get into those beds because those people will be discharged to homelessness. There is not a safe stable supportive place for them to go. This has created a logjam within the emergency department at hospital.
    a. Example: Great River Terrace HCRS/Groundworks/Windsor Wyndham Housing Trust have supportive services that serve these people in their home. People who have never participated in treatment before are finding success through this. It is expensive but it is a highly effective strategy. You cannot meet your most basic needs if you are living in a tent, on a couch, or situations that trigger substance abuse. We are voucher RICH – the state can pay for a person to be housed, but there is no house to put the person. Stigma needs to be addressed.
3. Workforce Issue
    a. Clinicians are leaving community mental health centers for Hub and Spokes, schools or hospitals for better pay.
    b. Difficult to match the reimbursement levels and wages these centers can provide versus Medicaid providers.
4. Connection between workforce challenges and effect on clients

a. Example: youth that have significant trauma and mental health issues often find themselves couch surfing, difficulty with primary care, creates a domino effect, intergenerational, Heather has lost clinicians to higher pay – they are taking care of their own families.

5. Barriers Associated with Stigma
   a. Folks stuck in emergency department waiting for beds; if there wasn't that barrier of stigma, more education, someone with a lived experience coming into clinical visit and guide that person through the transition, perhaps peer respite is an ok option with them but they just didn't know about it. A peer can break the habits or cycles. Sometimes 'unlicensed' people are not allowed in clinical areas.
6. Opportunity for VT and NH communication
   a. VT Department of Health allows peer support: it took Department of Health to work with VT Hospital Association. VT can help NH with this de-siloization. This reduces cost and allows choice.
7. Cost Stream-
   a. Mike Keiss asked about cost stream: what is the path of peer support, respite, supportive housing, incarceration, other tracks, what does this all cost. Public cost $4000 per day for psychiatric hospital, $40/day for outpatient. If you can allow the clinician to go talk with someone who really needs them right now, and have a peer sitting with someone who is slightly more stable.
8. Advocacy for non-clinical peer support staff to support folks in ED and address reciprocity in MH credentialing issue.

<u>Round 2 Notes:</u>

Discussion Table Members: Brian Sullivan, (NH), Richard Abel (NH), Carl Demrow (VT), Michael Kiess (Vital Communities, Workforce Housing Coordinator), Alice Nitka (VT), Tim Briglin (VT), Michael Cryans (Executive Councilor NH), Timothy Josephson (NH)

Discussion Points:

1. Pay parity and recruitment of staff
   a. Having 0 full time mental health counselors makes it really difficult to treat people. Once they become licensed, they leave commercial mental health centers to make more money.
   b. Leaves their most complex clients receiving care from the least experienced providers
   c. Student debt figures large.
   d. Currently start at 42K – more in VT than NH
   e. Cannot compete with current reimbursement
   f. Currently do tuition support, currently looking into loan forgiveness
   g. Current student debts are like 65-100K depending on where they went to school
   h. Without competitively paid staff cannot keep people out of hospital, ED
2. Housing
   a. Admissions to alternative to ED or psychiatric hospital are stuck in a log jam because of lack of transitional housing and backup at emergency department. Nowhere safe to discharge to for precariously housed people, people in early recovery etc.
3. Carl Demrow—current work
   a. Committee is dealing with creating new beds, hearing is that there is an increase in acuity that requires more acute beds. Need for community step down beds. There are high acuity beds that people cannot get into because we cannot move people OUT.
   b. May need a handful more beds, but acute beds are more expensive than community housing.
   c. Getting movement through the system is where Kate sees the most need, this will also decrease the overall cost.
4. Susan Seidler—current work
   a. Private place that has contract from HHS. Separate from West Central but share a lot of the same client population.
   b. Support folks in a non-clinical way. Use trauma informed model.

c. Reach out to each other and support each other.
d. Provide peer support.
e. One center in Lebanon, serve 9 towns in lower Grafton County; one center in Claremont serves Sullivan County.
f. Have 2 of 6 crisis beds in state of NH, alternative to psychiatric hospitalization.
g. Peer Support services including daily on-site support in Lebanon and Claremont, evening telephone support, and 24-hour support for guests of their crisis respite program, free for NH residents
h. Agency does not have transportation or budget for transport. Use salaried staff to transport.
i. The levels of stress, trauma, abuse, neglect, and insufficient coping mechanisms for these crises.
j. They do accept homeless people into crisis respite. This was a big learning curve for staff. As hard as this is going to be, we are contracted for 6 nights/7 days, but at the end of 7 days they have to leave due to contracts. There aren't always beds available, there are many shelters that will not allow you if you have a felony conviction. The cost of housing, the stigma, the shame. The Bridge Program – you have tons of vouchers but no physical building to send them to→ need for infrastructure

5. Opportunity for Vermont and NH Coordination
    a. The wait times patients see for evaluation or admission can be egregious. Policies vary as to whether or not individuals are allowed to see unlicensed peer support groups, as a means to timely service, but most do not allow this. We would like to see our staff/peers be able to support people in Emergency Department while they are waiting to discuss options/choices besides admission or after admission. Peer respite as an alternative to hospitalization or going home and knowing you have a peer support center in your community could be helpful.
    b. In State of NH, some hospitals do not allow unlicensed peers to go in. Even if the peer who is waiting on requests this support, he or she can't get it. Perhaps the solution is partnering the peer with a license person. Or, to be able to give that option.
    c. VT has done the above. Peer support is welcomed, encouraged, hospitals have overcome the fear of liability. It has been effective, gives support, access to support during mental health emergency, can sometimes divert psychiatric hospitalization.

III. Domestic Violence (Gender Based Violence)

Subject Matter Expert and Facilitator: Kate Rohdenburg (Program Director of WISE)

Major Themes:

1. Need to address data collection, only way to move forward is giving greater information
2. Feels like an institutional response is warranted for dealing with this early.
    a. Current state of sex education in schools preventing thorough discussions on domestic violence, needs to be reformed.
3. How do we prevent schools from avoiding this issue?
4. Important to consider how all gender identities are impacted by this issue, providing greater protections
5. Need to pursue

Round 1 Notes:

Discussion Table Members: Greg Crowley, James Bowling (Recorder), Linda Tanner (NH), Barbara Farnsworth (Manager of Community Health Improvement at Dartmouth Hitchcock), Alison Clarkson (VT).

Discussion Points:

1. Domestic Violence in state statute or other definitions can sometimes be broader and include exploitation of older adults by caregivers, sibling violence, adult children/parent violence, etc. Gender-based violence is a more specific definition of violence which WISE is trying to eradicate.

    a. WISE: category of violence that is the root cause of gender inequality (i.e. intimate partner violence, stalking)
2. Marsy's Law: it is trying to be passed, but struggling, in NH and has been vetoed in VT; need to add victim's bill of rights into state constitution
    a. Domestic Violence advocates across the country are split as to how effective this law would be
    b. Notable policy differences between the two states on this point
3. Educational differences between the two states
    c. VT mandates education around sexual violence prevention in schools
    d. NH: committee on prevention education, prevention education included in health standards
    i. Banned any non-academic surveys in schools and requires opt-in parental permission, which prohibits research and skews demographics.
3. Facts:
    a. Teenagers who experience dating violence are 4x more likely to experience it as adults.
4. Title IX
    a. Has been largely thought of as impacting campuses but applies to all federally funded schools. Not significant state-level support for schools to implement effective and compliant responses.
5. Problems with schools and their interventions
    a. Schools have an opportunity to ask questions regarding home life where other organizations can't, but often grapple with insufficient training, resources, or support to appropriately handle cases of gender-based violence.
    b. Representatives within schools are often not trained thoroughly
    c. Gender-Based violence warrants a broader community response not just school
    d. Sex-Ed should teach kids a language needed to discuss these issues
        i. Inconsistent curricula across all districts.
        ii. Parents can object to any of it and pull children out of schools
        iii. At the same time, students claim that they need more sex-ed
6. Next Steps: may be beneficial to reach out to a convener to establish a legislative council between NH and VT legislators
    a. Their joint focus areas:
        i. Data collection Youth Risk Behavior Survey (YRBS)
        ii. Sex- Education reform→ determining various issues (i.e. how early to hold sessions? How uniform should the educational models be between the two states? How do we make them prevention focused? Adding questions on dating and violence?)

<u>Round 2 Notes:</u>

Discussion Table Members: No legislators participated in this round.

Discussion Points:

1. Dove: attorneys who are willing to provide services for domestic violence;
2. Cultural victim blaming ignores research. For example: blaming victims who have had multiple abusive partners when in fact past abuse is a predictor of future abuse
3. Prevention: There is clear research available on the efficacy of protective factors around perpetrating and experiencing abuse. Next steps are making these more widely implemented. Barriers to implementing these have traditionally been misperceptions about dynamics of violence and connection to gender/power. We should work to spread data when possible, and also work on data collection to adjudicate misperceptions.
4. One place legislation plays a role is sex-ed: health-criteria
    a. Needs to be medically accurate not faith based

5. WISE: does not offer sex-education classes, but works within health-education classes and has a curriculum focused at the ways a healthy relationship can positively impact lives, whereas negative relationships and sexual violence can function in the opposite way.
    a. The controversy around sex-education is sometimes mistakenly applied to prevention education. WISE has developmentally appropriate lessons for students K-12 that address risk and protective factors needed to prevent violence before it starts. WISE views this as an essential element of building the safety and resiliency against gender-based violence.
    b. Learning opportunities focus on practicing skill and developing tools.
    c. Hope is to increase instances youth receiving reinforcing messages (from other teachers, parents, adults that are invested in youth). They are getting harmful messages from so many venues, need more places where positive are enforced.
6. Childhood trauma→ parenting challenges. Greater need to focus on the causal pathway so preventing is feasible→ Upstream solutions
7. Parents: next part of strategy

IV. Access to Primary Care Services:

Subject Matter Expert: Dana Michalovic (Executive Director at Good Neighbor Health Clinic)
Facilitator: Nancy DuMont (Alice Peck Day Memorial Hospital Department of Community Health)

Major Themes:

1. Non-clinical navigators should be utilized more to redirect and provide services
    a. Seen as a potential solution to issue of wait times
2. Vermont understood to have better services than NH, but they also struggle because of a low-density population, distance to care.
3. Cost of care seen as huge issue: providers often recommending services with no idea how much they will cost
4. Need to resolve the workforce issue and put a stop to the "revolving door of providers"
    a. Consistency of care leads to greater patient-provider trust
    b. Expansion of loan repayment programs for medical school and dental school
5. Proposed Potential Bills
    a. Loan repayment programs – this is available in VT (Registered Nurses program) and NH – RNs need this more than doctors given the pay difference
        i. If they want to go into public health, they want to be connected with a loan repayment program.
    b. Movement on a potential bill: providing transportation services and exemptions to individuals on parole in order to receive timely health care in the neighboring states.

Round 1 Notes:

Discussion Table Members: Jim Masland (VT), Charlie Kimbell (VT), Susan Almy (NH), Paul Manganiello (Medical Director, Good Neighbor Health Clinic).

Discussion Points:

1. Geography on VT side shows why access is an issue.
    a. General feeling of isolation on the VT side
2. Workforce Issue:
    a. Many primary care doctors are not accepting new patients. They find it difficult to maintain a business due to low reimbursement. There is an orientation to move to larger hospitals. This was addressed in VT two years ago by legislature.

    b. 6 out of 12 primary physicians bailed out to make more money somewhere else in a private practice
    c. It is hard to recruit doctors. The CVS-Aetna merger where there is a clinic in every CVS will outpace the hospital clinics.
    d. In the Keene area there is a walk-in clinic– this was good for access. Many people don't have the flexibility like professional people. People on the clock don't have the ability to take time out of their day.
    e. Telehealth as a potential help: specialty care was a big deal in New Mexico and this has led to availability to help in rural areas.
3. Loan Repayment
    a. Minimal movement on loan repayment in VT
    b. Movement on loan forgiveness in VT, possible way to attract workers
4. Dental is included in the primary care services that are lacking
5. Ways to expand service:
    a. Collaborative care nursing was started at Cheshire – registered nurses delivering care with cheap/free care – registered nurses would see patients with check-up like issues, allowing doctors to deal with more complicated care.
    d. VT and NH has a shortage of RNs – lack of instructors for VT RN programs since a Master degree is required
6. Telemedicine
    a. Between all the schools and hospitals – issue is that they are not reimbursed for it. With some insurance policies you have to see the patient face to face
7. Expanded Medicaid – VT has had this for a while. More of an issue in NH. Work requirement is in place for NH, though currently on hold.
    a. Larger employers are starting to offer a high deductible plan and the hospital says we will pay the deductible if you have an accident. People will shift to this and avoid primary care. This is an emerging problem – need to be aware of this trend. These plans have an annual wellness plan check. Hard to ask individuals who need a free well care visit and the doctor finds something and then the patient is charged and it is no longer a free visit. CVS will win because they will make these visits free and the hospital will not be able to do this - these systems are built to charge for things
8. Licensing Reciprocity:
    a. VT was the hardest and cost the most to get registered as doctor –licensing reciprocity would help this.
    b. Volunteer physicians have to get a pro bono license and having to deal with this bureaucracy is difficult. This is a deterrent. These MDs are not getting paid – they are volunteering.
    c. If this could be fixed that MDs and RNs and dentists can get registered on both sides – this would be better than paying $750 up front for a dentist license and then wait for reimbursement
    d. VT and NH should have a compact to share licensure as this could help increase capacity.
    e. Cost of licensure and the need for an original birth certificate and they keep it – person needs to get a new certificate for $60
    f. It appears to be cheaper and easier to get a license in NH compared to VT.

<u>Round 2 Notes:</u>

Discussion Table Members: Alison Clarkson (VT)

Discussion Points:

1. Trauma affects everything.
    a. Need to figure out prevention interventions, primary care is the obvious intervention route

2. Access to care is a burning issue at Good Neighbor Health Clinic – many gaps in care in VT and NH.
    a. Wait times inevitably implicated in this concern
    b. CVS minute clinics and urgent care centers- these visits have been timely for people and present a real opportunity for other primary care providers to take note from.
    c. Primary care access is not an issue for college students – good access as part of your tuition.
    d. There are no reminders that you need to be seen or for annual screening. Mammogram reminders come but not for dermatology patients who have risk for skin cancer there is no reminder.
    e. The 3 biggest challenges for access to care: A reminder or prompt to call or be seen by provider, the obvious necessity of coverage, and then the cost.
    f. Registered Nurses doing more visits combined with a social worker team can improve access.
    g. Community care coordinator and town nurse systems in VT – helps get people seen and reduces wait for care.
    h. We could utilize non-clinical navigators in greater capacity to coordinate care, potential help for wait times.
3. Problems with high deductible plans.
    a. If you go to the dermatologist for a routine check and they find a problem that is not dermatology related then this increased your bill.
    b. Big failing of health care system –they are recommending things they don't know the cost of.
4. Generational differences
    a. Many feel that they would rather speak to a real person, while doctors are insisting that they use online portals such as 'My DH'.
    b. This inevitably affects patient/doctor relations. Need to build trust and a relationship over person-to-person contact.
5. Loan repayment and forgiveness
    a. Medical students graduating with $250,000 debt and $400,000 from dental school. Taxpayers should not pick up what private institutions are charging – this is a policy question.
    b. Transparency of cost would be helpful – this is an issue with going to medical school. This is an issue for taxpayers.

V. Healthcare for Seniors:

Subject Matter Expert: Alison Morgan (Director of Service Link)
Facilitator: Laurie Harding (Co-Director of the Upper Valley Community Nursing Project)

Major Themes:

1. Importance of passing Family and Medical Leave Act (FMLA) in VT & NH
2. Main issue for people 65 and older is the cost of health insurance
    a. People assume that Medicare will pay for everything and in-home care, but it is still expensive. Many unaware that it is cheaper to work and keep employer healthcare
        i. Need to pursue higher reimbursement rates associated with Medicare/Medicaid
    b. NH cost of Medicare supplement plan, highest deductibles, monthly cost higher than most states
    c. Income level often too high, rendering many ineligible
3. Worthy to pursue funding for senior centers, service delivery, overall sense of belonging
    a. Potential to model this after state funding given to child and family centers
4. Legislative funding directed towards: end of life decision making, dementia, falls prevention, adult daycare would all be beneficial

Round 1 Notes:

Discussion Table Members: Richard Abel (NH), Tim Briglin (VT), Buff McLaughry (President of Four Seasons Sotheby's International Realty)

Discussion Points:

1. Need to reframe terms: older adults instead of senior/elders
    a. Terms can create stigma and discrimination (eg in employment)
2. Background on Upper Valley Older Adult Status
    a. 1/3 of population will be over 65
    b. NH, VT, ME 3 oldest states in country
    c. American Hospital Association (AHA Advocacy Work Group Survey Themes)
        i. Difficult to find in-home care
3. Problems with Medicaid
    a. Reimburses caregivers at low wages, difficult to attract workforce
    b. Turning down 85% of referrals because didn't have workforce to care for older patients
4. Available Resources and Organizations in NH & VT
    a. Bureau of Elderly and Adult Services in NH
    b. Division of Aging and Adult Services in VT
    c. Agencies on Aging in VT
    d. Service Link in NH
        i. Alison Morgan, director Service Link—dual state grant to Medicaid beneficiaries and link them with
        a. services provides information, Medicaid and Medicare counseling, care giver grants, help support
        b. people stay in their home, care taking reimbursements for family members who lose their job to take
        c. care of "patient"
        d. Tri-state Learning Collaborative (provides transportation and housing resources)
5. Buff, Chair of PCW, NH & VT
    a. Collected community input, heard about transportation and housing hurdles, tipping points program to
    e. help address hurdles, DH catchment area
    b. PCW becoming resource center for communities, funding through DH, 400 members
    c. Board includes social entities, like Haven, who disburse funding
    d. Cost of childcare can be strain on older adults
    e. People are pulled out of workforce to take care of older adults and take care of grandchildren
6. Richard Abel, NH House, City Lebanon, Commerce Committee
    a. Health insurance hearings on bill, includes private and public health insurance
    b. Family and Medical Leave Act (FMLA) bill in NH, currently vetoed, but tremendous need for people
    f. to keep job and be financially stable
    c. Medicaid/Medicare reimbursement is too low, shortage of providers, those in Southern NH
    g. move medical practices to Massachusetts for higher reimbursement rates or find a job in MA
    d. Calls from constituents who move to area thinking that they are near DH but can't find
    h. providers because reimbursement rates are lower in NH than VT
    e. Demand for services outpaces supply
7. Tim Briglin, VT House, Windsor-Orange-2, House Committee on Health Care
    a. Passion for healthcare economics
    b. VT is an aging state, elder care is an issue, and need to examine Medicaid reimbursements
    c. VT will pass FMLA, but will be vetoed by governor
    d. Policy angle includes ill, aging parents and maternal/paternal leave
    e. Strain on older adults to provide care for ill spouse or grandchildren

<u>Round 2 Notes:</u>

Discussion Table Members: Barbara Farnsworth (Manager of Community Health Improvement at Dartmouth Hitchcock), Rudy Fedrizzi (District Director of Public Health Services at Vermont Department of Health), Io Jones (Public Health Council)

Discussion Points:

1. Medicaid reimbursements are too low
    a. Individual cannot be reimbursed for taking care of sick spouse
2. VT PH Department pays little attention to older adults
    a. Need for high quality and dignified end of life care
    b. 1/8 dying at ICU at Cheshire, need to avoid over care
3. NH has no advance directives
4. Need to find ways to keep older adults engaged and connected
    a. Need to build age friendly communities
5. Barbara Farnsworth (Manager of Community Health Improvement at Dartmouth Hitchcock)
    a. Need to build capacity to support older adults staying at home in our community health
        a. improvement plan
        b. Social isolation is a problem, having senior centers, meals on wheels, transportation services
        c. could help
6. Rudy Fedrizzi-- District Director of Public Health Services at Vermont Department of Health
    a. Wants to see more intergenerational programs in housing, daycare
    b. Need to reconnect the extended family because older adults no longer live with younger families
    c. Lack of housing but plenty of bedrooms, pairing older adults with someone else and share living
        d. space could provide a solution to housing disparity and feelings of social isolation
        e. May be opportunity for work on this through the foundation set through VT Homeshare
7. Tri-State Learning Collaborative: https://agefriendly.community/
    a. Provides webinars, gray is the new green, aging workforce, how to deal with discrimination around
        f. aging, community interventions on dementia support
8. Opportunity for VT and NH collaboration
    a. NH struggles to pass a bill to study, let alone implement, a death with dignity policy which VT
        g. already has
        h. End of life care in general should be reviewed
            ii. NH didn't fund an end of life registry
            iii. Elder Forum in 3rd Friday in November, guest speakers from Endowment for Health

VI. Child Abuse and Neglect (Family Strengthening)

Subject Matter Expert: Erin Barnett (Dartmouth: Geisel School of Medicine)
Facilitator: Sara Kobylenski (Executive Director of the Upper Valley Haven)

Major Themes:

1. Rural isolation is particularly challenging
    a. People are isolated and do not have access to the things that help them be strong as families
2. Legal perspective—representation of children and families when they become involved in the public/child welfare system is concerning on both sides of the river
3. Solutions lie outside the governmental child welfare and more in communities
4. Pediatric-partnerships – growing in strength and proving to be successful for families
5. Grandparent/grandchild relations are being impacted as many parental rights are not transferred to grandparents/aunts/uncles, etc. who are taking on childcare as parents no longer are able to take care of children (from incarceration, substance use disorders, or other reasons)
6. Adequate housing, transportation, and income are all needed to keep people's level of stress, and toxic stress, at a point so that families can ensure children are getting what they need
7. Major issue of access to quality *and* affordable childcare

Round 1 Notes:

Discussion Table Members: Mary Jane Mulligan (NH), Ned Gordon (NH), Timothy Josephson (NH), Matt Houde (Government Affairs Representative from Dartmouth Hitchcock)

Discussion Points:

1. Family court legal system
    a. Structures that we have in place are based on family and community structures of the 1970s which don't fit current model of families and communities
    b. Getting representation for children and families is a problem in both states in child welfare cases People are by and large of low income, and although the systems for public legal representation are different in each state, neither has a way to give appropriate and independent legal help in a reliable way.
    c. Need for more circumstantial family representation, allowing for situations where Grandparents may need to take care of grandkids
        i. Only addressing grandparents involved in DCYF, but should be broadened out to anyone taking on guardianship
            iii. Mary Lou Beaver, works for Waypoint, is a good connection in NH because she is a content expert in grandparent issues
2. Jade's Law: legal frameworks parents have in order to protect their children
    a. Passed in 2019
    b. Background: Mother found out that her father was abusing her daughter (grandfather abusing granddaughter) and discovered that there was a loophole where she could not take out a restraining order on behalf of her child
    c. With passing of Jade's Law, this is now able to happen (with exception of it not being able to be used one parent against the other)
3. Need for early interventions;
    a. Current abuse and neglect system fails
    b. Dream (Mascoma administrator): have childcare center (starting at infancy) be right in the school buildings; after school programming
    i. Could partner with existing organization for funding and feasibility
4. HB11 Committee:
    a. Establishing Committee to study the effect of the opioid crisis, substance misuse, adverse childhood experiences (ACEs) and domestic violence for a post-traumatic stress disorder (PTSD) and other mental health problems in NH children and students
    b. Started with a superintendent reaching out to representative noting how opioid crisis and domestic violence was affecting students (PTSD)
5. Connection between substance use disorder and ACEs
6. Potential for positive relationship between schools and child care
    a. Seeing a mass burnout in teachers as this is affecting public school system
    b. Mascoma is seeing success coming out of having a school district social worker
    c. Importance of integrating a social-emotional learning (SEL) curriculum into everyday learning just like math, writing, etc.
7. Steps forward:
    a. Legislation runs into trouble when it's reactive, children have already reached the Division of Children Youth and Families (DCYF) before the proper intervention could have happened
    b. Instead, look at social determinants of health and the broader picture of how we make families stronger
    c. Still about getting to families and children early: takes a culture change of *when* we step in, *how* families trust the system, etc.

d. Courts used to address needs for families at time of truancy (absent 10+ days in a school year) and get health care/behavioral services for the family at this point. Presents a positive early entry point model that we should try to mimic.

Round 2 Notes:

Discussion Table Members: Buff McLaughry (President of Four Seasons Sotheby's International Realty), Owen Greene (Youth Health Equity Practice Fellow), Martha Hennessey (NH), Linda Tanner (NH), Jim Masland (VT).

Discussion Points:

1. Representative Hennessey has commissioned a bill to study 'grandfamilies' (grandparents who are taking care of grandchildren in all different ways); multiple legislations
    a. Renew the 'grandfamilies' and kinship type of programs because those who are becoming caregivers are not getting the same rights as the parents had without having to become foster parents, etc.
2. Graph of rise in opiate crisis (measured by Narcan administrations, overdoses), so has neonatal abstinence syndrome (NAS) counts among NH infants
    a. Crisis has been in childcare centers in last 5-7 years, but now children are becoming elementary school age and public-school system is needing help
    b. Education for teachers, first responders, other people who interact with children who are experiencing trauma from opiate crisis is being offered (through Erin's work)
3. Need for quality childcare
    a. Too expensive as of now; forcing younger people to drop out of workforce and stay at home
    b. Childcare providers are not making enough money, which can inevitably lead to high stress
    c. Acknowledge that public childcare systems are outdated, and not fitting current needs
4. Pediatric practices:
    a. Almost every family gets their family to their wellness check
    b. Includes brain science work that has been going on since 1990s
    c. Considers Adverse Childhood Experiences
        j. (10 adversities experienced before 18 that have been correlated, in aggregate, to increasing substance use, mental health disorders, teen pregnancy, poor health- including cardiovascular, diabetes, etc.- and life achievement outcomes)
    d. Resilience: capacity to do healing and build protection against experienced adversities
        i. Best to be built as early as possible (during childhood)
        ii. #1 factor of resilience: attachment to at least one caring adult
5. Family Leave
    a. Vetoed in NH and most likely will be vetoed in VT
6. Supported employment: showing success however needs to be further supported by affordable and quality childcare, housing, transportation, etc.
7. Towns that are caught in between major service areas
    a. Social isolation has been identified as one of the driving conditions for many of these issues
    b. Transportation, housing
8. Keeping workforce in the state (VT and NH are both experiencing this issue)
9. Small communities in VT are being hollowed out (similar in NH?)
    a. -School consolidation, lack of economic development are a few examples of reasons
10. LGBTQ community- needs to be considered always as any member of a minority community is more likely to experience these problems (substance use disorders, mental health, social isolation)