WINDSOR HSA COORDINATED CARE COMMITTEE MEETING
MEETING MINUTES
JANUARY 15, 2020

Attended by: Lisa Paquette-WRFP, Thomasena Coates- QI facilitator Blueprint, Jill Lord-MAHHC, Mary Boardman-MAHCC, Sandy Soho-OneCare, Jodi Frei- OneCare, Katie Muir-OneCare, Becky Thomas-Health Dept, Carla Kamel-CHT, Jenna Austin-CCN/MAHHC, George Karabakakis-HCRS, Rudy Fedrizzi-WRJ District Director, Jen Joy-VNH Clinical Nurse Liaison, Alaina Legere, Cedar Hill Clinical Nurse Liaison, Alice Stewart-RiseVT/MAPP, Ivan Levin, MD-MAHHC Primary Care, Amy Swarr-CCN/MAHHC, Sue Graff-AHS Field Director, Richard Marasa, MD-ED Medical Director, Sarah Doyle-Self-Management/MAHHC, Bob Crego- Executive Director SVTAHEC, Denise Dupuis-SASH, Erin Boxer-HCRS/MAHHC, Leesa Taft, DNP-MAHHC Primary Care, Melanie Sheehan-MAPP, Hannah Bianchi-Director of Provider Practices, Brenna Heighes-Analyst, MAHHC, Otelah Perry-Director of Quality, MAHHC, Pete Fellows-ECVEDD, Liz Sheehan-CCN, MAHHC, Sarah Wraight-ECVEDD

1. WELCOME AND INTRODUCTIONS – Jill opened the meeting by welcoming everyone and thanked everyone for attending and then delved into the action packed meeting.

2. MINUTES – not addressed

3. COMPREHENSIVE ECONOMIC DEVELOPMENT DISTRICT UPDATE – Sarah Wraight, Regional Planner from Two Rivers reviewed their catchment area. *The federally designated East Central Vermont Economic Development District (ECVEDD) consists of 40 towns within parts of Addison, Orange, Rutland, and Windsor Counties in Vermont. The towns of East Central Vermont are* ***Andover, Baltimore, Barnard, Bethel, Bradford, Braintree, Bridgewater, Brookfield, Cavendish, Chelsea, Chester, Corinth, Fairlee, Granville, Hancock, Hartford, Hartland, Ludlow, Newbury, Norwich, Pittsfield, Plymouth, Pomfret, Randolph, Reading, Rochester, Royalton, Sharon, Springfield, Stockbridge, Strafford, Thetford, Topsham, Tunbridge, Vershire, Weathersfield, West Fairlee, West Windsor, Windsor, and Woodstock.***

They have quite a large service area, and utilize a governing Board. Their purpose is to access and provide resources such as, technical services, grant management, development assistance, and transport, as well facilitate and support quality decision making for the benefit of entrepreneurs, businesses and communities in East Central Vermont. Today, their focus was on support for health care needs in the community. Sarah's colleague Kimberly Gilbert, has been working with MAPP to advocate for the inclusion of health chapters, and plans. Help to support towns grappling with issues of substances misuse, best practices documentation that can be utilized, and develop a resource library. Support for regulation of substance use at community events, etc. CEDS (Comprehensive Economic Development Strategy.) CEDS looks at strengths, weaknesses, opportunities and threats (SWOT) (See attached): The group participated in a SWOT analysis activity, and brainstormed ideas related to healthcare resources and services. Ideas include:

- Transportation is a weakness.

- Environmental concerns such as, tick borne disease and moisture/wet air which causes respiratory disease.
- Bringing more employers to the area for bedroom communities
- Expand Aging in Place community model
- Expansion of SASH. Integration of planning healthcare efforts.
- Work with towns, integration on policies, creating of a health plan in the towns.
- Expand substance use policy, healthy community design, health and wellness committee, policy/resource library.
- Substance misuse, recovery friendly workplace initiatives, productive way to address workplace and substance misuse.
- Bed bugs, and hoarding, which are related to mental health, but not a lot of resources for this. Affects housing and maintaining employment.
- Strong community partnerships, communication, support, data.
- Share list of our partners with Sarah
- Working with town government, could do a better job as a Regional initiative.
- Animals/pets are not always the top priority, however animals do have an impact on families. Either families have too many, healthcare for animals is needed, they need temporary homes, or need walks. We need a safety net for pets.

Pete added that this initiative is new to ECVEDD and they are not as familiar with healthcare planning as they are mostly infrastructure planners. However, these are the issues that need to be addressed in our communities. Jill shared that much of this work has been addressed through the CHNA and the main areas of focus are: Substance Use, Mental Health, Dental Care, and Housing. Jill will share the CHNA with Sarah.

Pete reported that the Regional Planning Commission in NH and Windsor are starting a Housing campaign called the "Keys to the Valley." This puts people near "stuff" using existing resources, such as Advance Transit transportation. A question was raised, do you talk about putting "stuff" near people? Springfield needs more "stuff." An idea includes bringing more employers to the area for bedroom communities. Not having enough employment fragments the groups that live there if there are not enough jobs. Sue pointed out that all these community partners have slightly different catchment areas, but our work intersects with other work that is happening in the region. Sarah reports that the CEDS update process will include public meetings, as well as draft documents. If you are interested in joining the email list, please sign the sign-up sheet. The next phase in the planning include developing strategies, and addressing weaknesses and threats we are facing. In the work that you do, what are key up and coming strategies focus in your field that should be highlighted in this plan? Having a plan in place can position us well for getting other funds. George added that embedded in all the things we do, we are creating community, creating connections, developing relationships and having conversations around community mental health, stigma and discrimination. Critical to have these conversations. These are our family, friends and neighbors. George also reported that the BRFSS Survey (Behavioral Risk Factor Surveillance System) indicates that Windsor and Orange County are statistically similar to the state. Orange County has the highest social isolation in the state. He adds that having

universal school meals, after care and other programs as the way this is done and expected would be a great benefit.

4. COMMUNITY HEALTH IMPLEMENTATION PLAN, LEARNING COLLABORATIVE – Jill shared that there are four workgroups concentrating on the following areas: Housing, Senior Health, Substance Misuse, and Strengthening Families. Each group has a Problem Statement, Root Cause, Aim Statement and are utilizing Best Practice Strategies and Results Based Accountability. They typically meet monthly and then every 6 months, the four groups get together as one for cross learning and sharing of their work. Please see workgroup summary. (Attached). Jill also reported that there is a parenting group called "Circles of Security" at Mt. Ascutney Hospital and Health Center. They will be implementing play groups. The Housing workgroup is working on finding a pilot town and plans to get more existing housing stock by finding underutilized areas and creating good rental situations. Jill also reported that Home Share Vermont is a resource for someone who could share a home with a person in need.

Jill reviewed the deaths and rankings rates for opiate overdose deaths. We are currently the 5th highest county for overdose opiate deaths (see attached). Jill would like to commend the work led by Dr. Marasa for implementing Medication Assisted Therapy in the ED, as well as creating MAHHC as a Naloxone distribution site. In addition, he helped implement Recovery Coaches in the ED. The CHIP workgroups are open groups if anyone is interested in joining forces with them.

5. ONECARE VERMONT – CARE COORDINATION OUTCOMES – Presented by Katie Muir via WebEx- (See Attached PowerPoint). Analysis of the Impact on KPIs, (Key Performance Indicators) using data from Care Navigator tool to see if we can see if there are any outcomes in the claims. The expectation is that we will see improved patient experience, increased utilization of preventative care services, reduced unnecessary emergency services utilization, reduced overall cost of care for members attributed to the ACO. (PKPY= per thousand per year). Medicare and Medicaid are the largest care managed population. Katie reviewed trends and shifts, how intervention actually impacted metrics. They did a pre and post analysis with 6 months of care managed patients, 12 mos before and 6 mos after. The "% with a Care Team Conference in the last year and the % with 2 or more care team members" will be two interventions that will be looked at closer as we go into 2020. It is unlikely that the decrease in ED visits before care coordination and after, is occurring by chance. Cannot be concluded what is causing the decrease. 74% of Medicare patients and 83% of Medicaid patients utilizing the ED had Mental Health diagnoses. ED is seeing a significant trend and OneCare VT will be continuing to monitor. Next steps include monitoring of KPI's, review of intervention group, create matched control group, further analyze drivers and learn more about specific interventions and their impact on trends. Jodi reported that she has been working closing with analytics group. She recommends taking a closer look at care coordination intervention and what is happening for patients, then evaluate of the quality of care coordination. There's a lot of different approaches. Looking at info in Care Navigator more closely for take a ways. Rudy surmised that it is not so surprising that they are trending upwards. Patients are getting more of their needs more attended

to outside of the office. A question was raised, what is used to measure are these statistics based only on visits with PCP? Katie reported that there is not enough robust data to include encounters with the care team. She is looking forward to getting more data on this. Jill added that we should recognize these initiatives for quality improvement efforts, as they may be making a difference and contributing to the decrease in ED visits.

6. QUALITY PROJECTS –

A. Diabetes – **Quality Improvement work includes:** Presented by Dr. Ivan Levin (see attached).

- Dr. Levin acknowledged the great team we have here at MAHHC. The data from today was achieved with help of Community Health Team, Practice Manager, and outpt services in the form of SASH.
- Data is collected for each provider and we are able to discuss and share results, to find ways to improve data.
- SASH helps us with checking on diabetic patients outside the clinic.
- There has been a 72% improvement over the last year.
- Special thank you to Liz Sheehan RN.
- Ongoing meetings with providers allow fluid communication and process improvement.

Dr. Levin shared the good news that we have an improved way to calculate the amount of diabetic patients. Jill noted that it has been transformational compared to 5 years ago. Jodi added that it can be easy to assume that an AIC was not taken. Many people who get AIC's are uncontrolled. Untested patients are a particular demographic, please encourage patient to have follow up appt.

B. HTN – Quality Improvement work includes: Presented by Liz Sheehan, RN (see attached)

Greenbelt Project

- 50% of MAHHC patients diagnosed with Hypertension have recorded blood pressures that are not in control.
- Lowering BP significantly lowers risk for cardiac disease, lowers healthcare costs.
- Staff have been educated on how to take a blood pressure correctly and repeat if greater or equal to 140/90 *(please note: Dr. Levin reports these guidelines have changed to 120/90 since the project started.)*
- This project utilized the DMAIC process ((Define, Measure, Analysis, Improve, Control)
- It was found that taking a second blood pressure is significant, and found to be "in control".
- A blood pressure log sheet was created and the plan is for this to be scanned into Cerner. Spot audits will occur to check in on compliance.
- Brochure created with device Apps available for stress management (Apple and Android) **Stop, Breathe, Think / Colorfy / Headspace / Sam / Happify / Sanvello /Digipill.** These apps have been reviewed by the project team, and vetted by Risk Management.

7. AGENDA ITEMS – Due to lack of time, the meeting was adjourned with agenda items not addressed. These items will carry over to next meeting. The previous Evaluation of Windsor HSA Community Collaborative survey that was distributed will be redistributed for those of you who were unable to participate.

8. NEXT MEETING- The next meeting of the Windsor HSA Community Collaborative Committee is scheduled for April 15, 2020 at 8AM in the Boardroom at MAHHC.

Respectfully recorded,

Mary Boardman
Administrative Assistant