OneCity Health Care Models Committee
January 7, 2016
199 Water Street, 31st Floor, New York, NY
4:00 – 6:00 PM

In Attendance:
Joseph Masci, Committee Chair
Anna Flattau, OneCity Health Chief Clinical Officer
Rose Madden-Baer
Dave Chokshi (by phone)
Cecilia Jordan
Esther Moas
Hillel Hirshbein (by phone)
Chris Norwood
Sudha Acharya
Elizabeth Dubois
Eric Manheimer
Pamela Sass
Lauren Johnston
Dona Green
Jack Dehovitz

Observer:
Moira Dolan

Not in attendance:
Christina Jenkins, CEO OneCity Health Services
Robert Faillace
Gary Belkin

Committee Support:
Lindsay Donald
Mark Hurwitz
Samantha Kumar
Sunghee Oh

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<th>Item</th>
<th>Notes</th>
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<tr>
<td>1. Review and Approval of Minutes</td>
<td>• October 26th and December 3rd meeting minutes approved</td>
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| 2. OneCity Health Updates | • Update provided by OneCity Health Chief Clinical Officer, Anna Flattau:  
  o Review of care model committee charter, roles and responsibilities of care models committee  

Follow-up items
• Schedule retreat for care models committee in late February or March |
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<tr>
<td>3. Presentation of Care Transitions Model</td>
<td>Presentation of care transitions care model by Anna Flattau</td>
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- **Key discussion items included:**
  - Overall goal is to reduce 30-day readmission for patients at high risk of readmission by focusing on modifiable factors
  - Pay for performance metrics include potentially avoidable readmissions and emergency room visits, patient satisfaction and access to preventive or ambulatory care
  - Identifying risk factors - risk screening tool for readmission reductions to be further developed by a workgroup to standardize and unify risk factor screening across the PPS
  - Standardizing fundamental care transitions processes and care transitions plans for all hospitalized patients; implementation planning will include prioritizing core improvements for first-phase work
  - Assigning care management support for an appropriate period
  - Roles and responsibilities of transition managers
  - Evolving and iterative implementation planning based on system and site characteristics, data analytics and shared best practices

- **Edits to be made:**
  - Inpatient-outpatient provider communication emphasized as a focus area for development (e.g. attempted phone call to PCP during inpatient stay, timely and effective sharing of care plan)
  - Prescription pre-filled and ordered upon discharge with timely medication reconciliation added as a strategy
  - Access to clinical information for post-discharge providers included as a function of the hospital follow-up contact information for discharged patients
  - Engagement of the emergency department as a critical partner in readmissions reduction added as a focus area
  - Emphasized need to align implementation planning with ongoing initiatives especially Meaningful Use

- **Decisions made:**
  - Motion passed to recommend Care Transitions Care Model to Executive Committee to move forward with implementation planning

- **Follow up items:**
  - Care Model to be edited and reflect discussion items above and distributed to Committee
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<td></td>
<td>o Summary page of the Care Transitions Care Model to be created and distributed</td>
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<td>o IT capability to be explored for tracking readmissions for patients followed by specific community-based partners</td>
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<td>o Workgroups to be formed to continue discussion for subtopics as outlined in care model</td>
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<td>4. Next steps</td>
<td>• <strong>Upcoming agenda topics:</strong></td>
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<td>o Presentations of initial care models for Health Home at Risk, Integration of Primary Care and Behavioral Health Services, and ED Triage</td>
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<td>• Next committee meeting: February 8</td>
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<td>o Additional meeting to be scheduled in February</td>
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