OneCity Health Care Models Committee

Meeting Summary

April 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
Cecilia Jordan (by phone)
Chris Norwood
Christina Jenkins, CEO OneCity Health Services
Dave Chokshi
Eric Manheimer
Hillel Hirshbein
Jack Dehovitz (by phone)
Pamela Sass
Robert Faillace (by phone)
Rose Madden-Baer
Esther Moas (delayed arrival)

Not in Attendance:

Dona Green
Lauren Johnston
Moira Dolan (Observer)
Elizabeth Dubois
Gary Belkin
Sudha Acharya

Committee Support:

Samantha Kumar

Item	Notes
1. Review and Approval of Minutes	• February 8, 2016 meeting and March 16, 2016 retreat minutes *approved*
2. OneCity Health Updates	• Update on Project Roll-Out: Project 11, Asthma, ED Care Triage, Care Transitions • Project Advisory Committee (PAC) meeting schedule will be distributed when it is available
3. PPS Performance Risk	Presentation of PPS Performance Risk by Anna Flattau, OneCity Health Chief Clinical Officer *Key discussion items included:* • Progress on Performance Enablers ○ On-track: partner engagement is ongoing ○ On-track or delayed with significant risk: Clinical project design and implementation, organizational transformation, IT infrastructure (care management

Item	Notes
	platform, connectivity for population health management), CSO staffing and team building ○ Delayed and CSO course correction needed: Partner contracting and funds flow ▪ Payment model under final stages of development • Clinical Implementation Risks ○ On-track to meet commitments: ▪ Project 11: next phase will focus on meaningful linkage to insurance and primary care ▪ MH/SA: no known unmanageable risk ▪ HIV (Discrete Projects): Care model to be developed ○ On-track with significant addressable risk: ▪ PC/BH Integration: Behavioral health staffing, sustainable model for colocation ▪ Palliative Care: training and education, longer visits for advanced illness management ▪ Asthma: Community health worker shortage, unfeasible engagement metric ▪ Cardiovascular Improvement: Burdensome engagement metric ▪ Integrated Delivery System: IT discovery vendor has started work and PCMH plans to begin upon partner contracting ○ High failure for speed/scale or sustainability: ▪ ED Care Triage: Care management staffing and workflows ▪ Health Home At-Risk: Care management staffing and workflows ▪ Care Transitions: Care management staffing and workflows • Organizational Transformation Efforts ○ Low performance risk: ▪ Financial sustainability ▪ Governance ○ High performance risk: ▪ Workforce strategy: In development with inputs from PPS-wide workforce survey • Challenges with defining workforce future state of community health workers and in behavioral health

Item	Notes
	• Utilizing, enabling and engaging the resources and roles of community-based organizations • Training and education for care management – creating time, space, and funding ▪ Cultural competency/Health literacy strategy • Performance Payments by Risk Tier ○ Designing work to maximize earned payments while achieving sustainable transformation ○ Mechanism to identify systemic barriers common to workflows across projects *Follow up items:* • Send open CSO job descriptions for distribution • Summer 2016: CSO to convene governance committees and local clusters of partners for "tabletop exercise" of the future state of projects building into an integrated delivery system
4. Performance Dashboard	Presentation of Performance Dashboard by Anna Flattau, OneCity Health Chief Clinical Officer *Key discussion items included:* • Four overlapping key areas of metrics: ○ Performance Dashboard – meaningful and measurable to assess functioning of PPS ○ Pay-for-Performance Metrics ○ Contract Metrics ○ Quality Improvement Metrics • Measuring effectiveness of patient outreach and self-management ○ Social media strategies ○ Medication knowledge and adherence tools (e.g. Morisky Medication Adherence Scales) The Committee reviewed a proposed Performance Dashboard and discussed additional and substituted measures that may better reflect performance in early years, including proxy measures. *Potential edits discussed:* • Add current readmissions rate across the PPS and the estimated population that had avoidable readmissions • ED Care Triage ○ Rather than follow up appointments for all patients, define appropriate follow up appointments based on patient need

Item	Notes
	○ Defining long-term, motivating metrics that provides feedback to partners for improvement and builds accountability (e.g. reasons why a patient with an existing PCP was not able to visit the PCP before presenting at the ER) ○ Track follow up appointments for a subset of diagnoses (e.g. asthma and CVD) ○ Building blocks of successful implementation (e.g. fax transmissions of care plans) ○ Look at metrics from existing ED efforts ○ Indicate where NYC H+H is a proxy for the PPS • Care Transitions ○ Add if the care plan has been sent the PCP upon discharge • Asthma ○ Missed school days – presenteeism and absenteeism ○ Number of completed home visits by community health worker and home visit update provided to PCP • Cardiovascular disease ○ Potential HEDIS/PQRS/PCMH measures that sites are already measuring • Palliative Care ○ Consider additional metrics to track in GSI in addition to data collection required by state *Follow up items:* • CSO to revise performance dashboard to incorporate a new subset of metrics that are feasible and may be proxies to reflect PPS performance • CSO to schedule Care Models Committee conference call to review new version for recommendation
5. Next steps	• *Upcoming agenda topics:* ○ Clinical Integration Needs Assessment ○ Training and Education Plan • Next committee meeting: May 18, 2016 • Conference call to be scheduled prior to next meeting to review revised Performance Dashboard