

OneCity Health Care Models Committee

May 3, 2016
 Conference Call
 4:00 – 5:00 PM

Conference Call Summary

In Attendance:

Joseph Masci, Committee Chair
 Anna Flattau, OneCity Health Chief Clinical Officer
 Cecilia Jordan
 Chris Norwood
 Dona Green
 Esther Moas
 Gary Belkin
 Jack Dehovitz
 Lauren Johnston
 Pamela Sass
 Rose Madden-Baer
 Sudha Acharya

Not in Attendance:

Christina Jenkins, CEO OneCity Health Services
 Dave Chokshi
 Elizabeth Dubois
 Eric Manheimer
 Hillel Hirshbein
 Moira Dolan (Observer)
 Robert Faillace

Committee Support:

Samantha Kumar

Item	Notes
1. Revised Performance Dashboard	<p>Presentation of Revised Performance Dashboard by Anna Flattau, OneCity Health Chief Clinical Officer</p> <p><i>Key discussion items included:</i></p> <ul style="list-style-type: none"> • Performance dashboard is PPS-level view of implementation and performance of clinical projects • Goal of the performance dashboard is to include meaningful and measurable metrics • A draft of the performance dashboard was discussed at the April 7, 2016 Care Models Committee meeting and revisions were made after the Committee’s comments • ED Care Triage <ul style="list-style-type: none"> ○ Removed actively engaged patient definition because of difficulty interpreting meaningfulness ○ Changed PCP follow up metric from 30 to 14 days

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	<ul style="list-style-type: none"> ○ Narrowed the denominator for ED linkage metrics to patients who have specific medical conditions that are highly likely to require PCP follow up within 2 weeks <ul style="list-style-type: none"> ▪ Once the metric design is recommended, the list of diagnoses to be included in the metric will be workshopped and finalized with E.D. and ambulatory care colleagues ▪ Committee members are invited to submit further advisory input on appropriate diagnoses ▪ Suggestion noted of considering ‘syncope’ in diagnosis list ▪ This metric is an indicator of primary care linkage; the group of patients included in this metric is not the same as the group of patients who require care management ▪ The group of patients who do not meet the metric’s goal can be further studied to develop appropriate interventions for them ● Care Transitions <ul style="list-style-type: none"> ○ Changed metric on timeliness of referral to transition management to reflect the time between referral and discharge from hospital, instead of the time between admission to hospital and referral ● Asthma <ul style="list-style-type: none"> ○ Changed the metric reflecting use of controller medications to reflect if controller medication was prescribed, rather than if patient reported adherence. This change was due to limitations of current version of care management HER. ○ Removed metric about asthma-related ED visits due to concern that this metric is sensitive to problems with primary care access. ○ Noted that asthma metrics extracted from GSI will reflect the patient population followed in the community health worker program, not all patients seen in clinical settings ○ <i>Committee requested an additional metric to track completion of home remediation services for patients referred for this service.</i> ● Health Home At-Risk <ul style="list-style-type: none"> ○ Changed metric on care coordination to be measured in terms of timely case conferences ○ <i>Committee requested to remove the metric on number of care plans completed, and replace it with</i>

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	<p><i>the conversion rate (percentage of referred patients who were enrolled)</i></p> <ul style="list-style-type: none"> ○ <i>Committee requested to remove the metric on duration of program enrollment, as more appropriate for Quality Improvement metrics than for Performance Dashboard.</i> ● Primary Care Projects <ul style="list-style-type: none"> ○ Removed metric related to cardiovascular self-management plans ○ Added metric reflecting creation of hypertension registries <p><i>Decisions made:</i></p> <ul style="list-style-type: none"> ● Motion approved to recommend revised performance dashboard to Executive Committee <p><i>Follow up items:</i></p> <ul style="list-style-type: none"> ● Performance dashboard to be edited to reflect italicized items above and distributed to Committee <p><i>Addendum:</i></p> <ul style="list-style-type: none"> ● <i>Dr. Belkin recommended in follow-up communication that the Behavioral Health project include a metric reflecting enrolment of patients with positive depression screen into integrated treatment program.</i>
2. Next steps	<ul style="list-style-type: none"> ● <i>Upcoming agenda topics:</i> <ul style="list-style-type: none"> ○ Clinical Integration Needs Assessment ○ Training and Education Plan ● Next committee meeting: May 18, 2016