OneCity Health Care Models Committee

Meeting Summary

May 18, 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
Chris Norwood
Christina Jenkins, CEO OneCity Health Services
Dave Chokshi (by phone)
Dona Green (by phone)
Elizabeth Dubois (by phone)
Esther Moas
Lauren Johnston
Moira Dolan (Observer)
Pamela Sass
Robert Faillace (by phone)
Rose Madden-Baer
Sudha Acharya

Not in Attendance:

Eric Manheimer
Hillel Hirshbein
Jack Dehovitz
Gary Belkin

Committee Support:

Madeline Rivera
Samantha Kumar

Item	Notes
1. Review and Approval of Minutes	• April 7, 2016 meeting and May 3, 2016 conference call minutes *approved*
2. OneCity Health Updates	• Next phases of implementation design ○ Committee members were invited to volunteer or to nominate a candidate for workgroups on project implementation design, including for advanced illness management in palliative care; ED care management; behavioral health co-location; and integrated care management strategy and implementation.
3. Clinical Integration Needs Assessment	Presentation of draft of Clinical Integration Needs Assessment by Anna Flattau, OneCity Health Chief Clinical Officer *Key points included:*

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	• NYS DOH requires an approved Clinical Integration Needs Assessment by Care Models and Executive Committee by June 30, 2016
	• Subsequent to finalizing of the Needs Assessment, the Clinical Integration Strategy will be developed over the next 3-9 months
	• Mapping of partner network has incorporated multiple layers and approaches to information gathering
	• Clinical integration needs can be framed by six categories: access, linkage, information technology, integrated clinical care, care management and population health, and performance management
	• Key access domains: primary care, urgent care, other clinical (specialty) outpatient access, uninsured, and social and community-based services
	• Key linkage domains: primary care, care management services, specialist services, and community-based social services
	  ○ Improved protocols for appointment scheduling can facilitate linkage between organizations
	• Key information technology domains: data sharing and interoperability, care management support, and support for access and linkage
	  ○ Ongoing efforts to standardize care plan elements are being discussed between PPS's, to facilitate exchange of care management information
	• Key integrated clinical care domains: physical and behavioral health (including substance abuse), pharmacist expertise, palliative care, and community-based services
	• Key care management and population health domains: identification of patients with care management needs and enhanced resources for care management and population health
	• Key performance management domains: PPS performance and partner performance
	  ○ Performance dashboard as previously reviewed and recommended by the Committee reflects performance across interfaces
	  ○ PPS and partner performance metrics will continue to evolve throughout the DSRIP project
	
	The following topics were discussed:
	• The definition of clinical integration should emphasize that community-based settings are included
	• The concept of partner capacity was discussed as reflecting not only ability to increase volume of service, but as ability

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	of the partner to offer new models of addressing health-related issues. In particular, community organizations may have alternate approaches to addressing conditions that have traditionally been addressed in clinical settings. • Access is related to capacity for patient volume; identifying and leveraging unused capacity will be an important strategy, along with increasing capacity in areas such as primary care. • Access should include the need for access to culturally competent services. • Access should include access to care in different settings (e.g. home-based care) • A centralized process for linkage can enhance connection to the right services and provide an understanding of capacity across partners; provide 24/7 assistance; provide mechanisms to manage overflow of demand and support cross-coverage; and create a greater range of options for linguistically and culturally competent navigation. • Information technology should include patient interfaces such as telehealth, mobile apps (e.g. scheduling, triage for urgent care), personal health records aligned with Meaningful Use, HIPAA compliant texting, and direct messaging. • Integrated clinical care should include proactive disease management along the continuum of care, including registry management and alerts on gaps of care; however, gaps of care alerts require clear accountability for follow-up • Integrated clinical care should include identification of a primary accountable provider (e.g. primary care provider or alternative) and assignation of roles and responsibilities among providers *Follow up items:* • Revise based on input from Committee and seek additional feedback from stakeholders • Distribute revised version by email to be considered for recommendation
4. Training and Education Plan	Presentation of Training and Education Plan by Anna Flattau, OneCity Health Chief Clinical Officer *Key points included:* • Training and Education Plan will be co-recommended by the Stakeholders Committee and Care Models Committee to the Executive Committee • The Training and Education Plan is a framework for training practitioners and other professional groups

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	• Separate training strategies are in development for cultural competency and workforce transition • Training will be designed to meet the needs of different learner types (professional backgrounds and roles) and will leverage a range of training modalities (format and intensity) • Training design will vary depending on complexity of content, difficulty of behavior change and user acceptability • Existing training venues will be used when feasible *The following topics were discussed:* • Training modalities can include simulation and role-plays • Training for operational staff includes paraprofessionals, and others that can provide "high-touch" support in addition to clinical services • Community-based organizations will receive training as well as clinical partners • Trainings on related topics can be clustered (e.g. motivational interviewing with tobacco cessation or with medication reconciliation • Cultural competency can be integrated into all topics • Coaches such as NYCHH's Ambulatory Care Coaches can support enhanced methods, approaches and skills. • Tracking of participation should be done with minimal data collection burden on partners. *Decisions made:* • Motion passed to recommend Training and Education Plan to Executive Committee
5. Next steps	• *Upcoming agenda topics:* ○ Review of clinical workflows by setting • Next committee meeting: June 28, 2016