OneCity Health Care Models Committee

Meeting Summary

June 28, 2016
199 Water Street, 31st Floor, New York, NY
4:00 – 6:00 PM

In Attendance:

Anna Flattau, OneCity Health Chief Clinical Officer
Cecilia Jordan
Chris Norwood
Christina Jenkins, CEO OneCity Health Services
Esther Moas
Hillel Hirshbein
Jack Dehovitz
Lauren Johnston
Oxiris Barbot
Pamela Sass (by phone)
Robert Faillace (by phone)
Rose Madden-Baer
Sudha Acharya (by phone)
Talya Schwartz

Not in Attendance:

Dave Chokshi
Dona Green
Elizabeth Dubois
Eric Manheimer
Gary Belkin
Joseph Masci, Committee Chair
Moira Dolan (Observer)

Committee Support:

Lindsay Donald
Madeline Rivera
Samantha Kumar

Agenda Item	Notes
1. Review and Approval and Minutes	• May 18, 2016 meeting minutes *approved*

2. One City Health Updates	• Care Models Committee Membership – introduction of new members Talya Schwartz and Oxiris Barbot
	• Update on OneCity Health Contracting
	  ○ Iinformational webinars were held for partners on metrics and payment model in May and June 2016
	  ○ Comprehensive Schedule B to be released to partners on July 5, 2016. The contract term for the

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	Comprehensive Schedule B ends March 31, 2016 with the goal of shifting to value-based payments in the subsequent years.
	• Implementation Workgroups
	  ○ Workgroups are progressing in addressing strategic questions for new phases of project implementation
	  ○ Care Models Committee will be provided with implementation updates as projects progress

3. Clinical Integration Needs Assessment	*Key discussion items included:* • Revised version of the Clinical Integration Needs Assessment has been circulated to committee members via email prior to this meeting, and as a printed document during this meeting • Comments from May 18, 2016 Care Models Committee meeting were incorporated into the document *Decisions made:* • Motion passed to recommended Clinical Integration Needs Assessment to be submitted to the New York State Department of Health

4. Review Clinical Workflows	Presentation of Clinical Workflows by Anna Flattau, OneCity Health Chief Clinical Officer
	
	Key discussion items included:
	• 11 projects across care settings are in varying stages of implementation
	• Committee will today review 3 draft workflows that illustrate project implementation by care setting – primary care, inpatient medicine and emergency room – to provide feedback and advise on their design and content
	• Objectives of setting-based workflows:
	  ○ Shift in implementation planning from specific projects to development of an integrated delivery system
	  ○ Clarity of communication on how OneCity Health's work supports care in specific settings
	  ○ Identification of additional key strategic areas that are fundamental to developing an Integrated Delivery System (e.g. unstable housing, substance abuse, access to specialty palliative care)
	• Primary Care Workflow - intersection of Health Home At-Risk, HIV, Project 11, Cardiovascular Disease Management, Integration of Palliative Care and Integration of Primary Care/Behavioral Health projects in the adult primary care setting
	  ○ Process for verification of and linkage to insurance will differ between sites
	  ▪ Health plans can contribute to checking eligibility

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	○ Considerations should include the following time constraints: How long do the screenings take? And in a different language? And how does it impact cycle time? ○ In screening for factors that indicate potential need for care management, considerations should include: ▪ Different sites can consider locally at what point in their patient workflow to screen for care management needs, including determinants such as unstable housing ▪ Adapted version of Care Management Screening Tool, especially the section related to social determinants, may be a helpful example to sites as an example of a screening tool for primary care settings. ▪ Screening can be considered at patient check out to be addressed at the next visit; or at registration (with translation of any printed version) ○ Tasks within a single visit will require prioritization by the team based on complexity and urgency on an ongoing basis, and can be informed by pre-visit planning ▪ EHR support can be considered to help determine appropriate intervals for addressing different tasks • Inpatient workflow – intersection of Care Transitions, Health Home At-Risk, Project 11 and Palliative Care projects in the adult inpatient setting ○ After evaluating existing screening tools and data algorithms, current criteria for identifying high risk patients for care transitions involves provider judgment with structured thinking. Will evaluate and evolve this strategy in the future as implementation continues. ○ Consider developing a checklist for the Transition Management Team (TMT) upon discharge to make sure the patients' basic needs are coordinated ○ TMTs would benefit from access to community based care management hubs that link to resources in a geographic area or specific cultural needs ○ Care Transitions project will generate data to understand unmet resource needs • ED workflow – intersection of ED Care Triage, Health Home At-Risk, Project 11 and Palliative Care projects in the adult ED setting ○ Consider using the volume of visits and discharges by shift to determine when a home care planner or care manager is needed

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	Edits to be considered:
	• Adult Primary Care Workflow
	  ○ Indicate that pre-visit planning does not directly include the patient
	  ○ Change "as needed" to "as eligibility allows" for connection to insurance
	  ○ Note that identification of insurance status also supports accurate billing for insured patients
	  ○ Add BMI/weight to screening before visit
	  ○ Consider including in workflow the identification of the patient's own goals for the visit, patient's questions, and current medications
	  ○ Consider adding text that explicitly states that the workflow contains essential functions but the sequence is dependent on the local environment
	• Inpatient workflow
	  ○ Consider noting places of potential redundancy or conflict among decision makers and a venue for a shared solution – TMT, inpatient team, external care coordinator
	  ○ Consider noting resource of short-term stays at sub-acute rehabilitation facilities as a mechanism to care for complex patients while transition to home is being prepared
	  ○ Define more clearly the relationship between discharge planning and transition management
	• ED workflow
	  ○ Add linkage to Health Home and to home nursing

5. Next Steps	• OneCity Health Governance Half-day Retreat: July 28, 2016
	• Next meeting: August 10, 2016
	• Upcoming Topics:
	  ○ HIV Care Model
	  ○ Project 11 update
	• Additional topics for future
	  ○ MH/SA project update
	  ○ Integrated Delivery System update and review of PCMH and IT integration