

OneCity Health Care Models Committee

August 10, 2016
 199 Water Street, 31st Floor, New York, NY
 4:00 – 6:00 PM

Meeting Summary

In Attendance:

Anna Flattau, OneCity Health Chief Clinical Officer
 Cecilia Jordan (by phone)
 Chris Norwood
 Elizabeth Dubois (by phone)
 Esther Moas (by phone)
 Jack Dehovitz (by phone)
 Joseph Masci, Committee Chair
 Lauren Johnston
 Oxiris Barbot
 Pamela Sass
 Robert Faillace (by phone)
 Rose Madden-Baer
 Talya Schwartz

Not in Attendance:

Christina Jenkins, CEO OneCity Health Services
 Dave Chokshi
 Dona Green
 Eric Manheimer
 Gary Belkin
 Hillel Hirshbein
 Moira Dolan (Observer)
 Sudha Acharya

Guest attendees:

Eunice Casey, NYCHH
 Terry Hamilton, NYCHH
 Marjorie Momplaisir-Ellis, OneCity Health

Committee Support:

Lindsay Donald
 Samantha Kumar

Item	Notes
1. Review and Approval of Minutes	<ul style="list-style-type: none"> June 28, 2016 meeting minutes <i>approved</i>
2. OneCity Health Updates	<ul style="list-style-type: none"> The Care Models committee will review outputs from implementation workgroups that have been held this far Additional workgroups to be convened for cardiovascular disease management, asthma and HIV projects, and for PPS care management strategy

Item	Notes
3. HIV Care Model	<p>Presentation of HIV Care Model by Anna Flattau, OneCity Health Chief Clinical Officer</p> <p><i>Key points:</i></p> <ul style="list-style-type: none"> • Background and context <ul style="list-style-type: none"> ○ In 2013, only 54% of individuals living with HIV/AIDS in NYC were retained in HIV care ○ Core strategies to engage individuals with HIV or those that are at-risk include prevention, linkage and retention in care, and viral suppression • OneCity Health HIV Project <ul style="list-style-type: none"> ○ The HIV project (4.c.ii) is a population health project addressing early access to and retention in HIV care ○ Project goals and implementation design will align with the New York State Ending the Epidemic (ETE) Initiative and other ongoing state and citywide initiatives ○ The HIV project will consist of the following five initiatives: <ul style="list-style-type: none"> ▪ Integration of HIV screening and improved linkage to care ▪ Pre-exposure prophylaxis (PrEP) for high-risk negatives ▪ Peer support program ▪ Patient education and participation ▪ Virology fast track plus ○ As a public health project, the HIV project does not have State-defined speed and scale requirements or pay-for-performance outcomes metrics ○ Strategic approach: <ul style="list-style-type: none"> ▪ Align with and leverage the New York State Ending the Epidemic (ETE) Initiative and other ongoing state and citywide initiatives ▪ Drive overall transformation goals of DSRIP to reduce avoidable hospital and emergency department utilization ▪ Leverage OneCity Health partner network, resources and expertise ▪ Improve and expand patient engagement in program design, management, evaluation and improvement ▪ Maintain a patient-centered and culturally competent focus on delivery system reform that improves the patient experience • Implementation Strategy

Item	Notes
	<ul style="list-style-type: none"> ○ The implementation strategy of the five initiatives of the HIV project will include: <ul style="list-style-type: none"> ▪ Understanding current HIV operations and services in clinical and community-based social service settings ▪ Disseminating best practices in the HIV service community ▪ Improving multidisciplinary service integration and linkages between care settings ▪ Leveraging existing DSRIP efforts in care management, clinical integration, community outreach, training and cultural competency to support improvements in HIV prevention and treatment ○ Opportunity for a variety of partner types to be involved in the five initiatives of the HIV project ● Phase 1: Implementation Planning <ul style="list-style-type: none"> ○ Implementation of the HIV project will be phased over time ○ Workgroups will develop implementation plans for phase 1 activities: <ul style="list-style-type: none"> ▪ Screening and referral for PrEP in the primary care setting ▪ Screening and linkage to increase reach and leverage existing resources ▪ Augmenting care team with peers and promoting education and training ○ Pre-exposure Prophylaxis (PrEP) for High-Risk <ul style="list-style-type: none"> ▪ Key activities across care settings: improve sexual history skills and documentation, improve PrEP screening, receive PrEP referrals, prescribe PrEP as appropriate ○ Screening & Linkage <ul style="list-style-type: none"> ▪ Key activities across care settings: improve referral processes, share best practices for screening workflows and protocols, support linkage and navigation, share best practices for linkages to services ○ Peer Support <ul style="list-style-type: none"> ▪ Key activities across care settings: share best practices for peer support programs, promote the establishment of peer initiatives <p><i>Discussion:</i></p> <ul style="list-style-type: none"> ● PrEP implementation in Phase 1

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	<ul style="list-style-type: none"> ○ Existing resources such as the NYCHDOH Public Health Detailing Program can be leveraged for on-site technical assistance for identifying patients and appropriately counseling them on PrEP ○ Sensitivities around HIV disclosure status must be embedded in care practices ○ Consider targeting OBGYN practices to identify patients eligible for PrEP ○ CBOs may connect with groups at high risk of HIV but need improved connections to health care services ● Implementation should consider the needs of sub-populations <ul style="list-style-type: none"> ○ Sub-populations to consider include individuals with unstable housing, young men who have sex with men, transgender individuals, heterosexual women with a background of domestic violence and abuse and individuals with behavioral health comorbidities ○ The population that is not retained in HIV care is different from the general HIV population and may need innovative strategies for engagement ● Care management services (including Health Home At-Risk) can support community-based outreach, linkage and navigation for high-risk individuals and those lost to care ● Gaps in information sharing make it harder to identify individuals who are truly no longer retained in HIV care ● Access to HIV care can be broadened by having more primary care providers engaged in HIV treatment <p><i>Decisions made:</i></p> <ul style="list-style-type: none"> ● Motion passed to recommend HIV Care Model to Executive Committee
4. Project 11 Update	<p>Presentation of Project 11 Update by Marjorie Momplaisir-Ellis, OneCity Health Senior Director, Engagement & Collaborations</p> <p><i>Key points:</i></p> <ul style="list-style-type: none"> ● Phase 1 focused on PAM administration for the uninsured (time period ending March 31, 2016) ● Phase 2 underway (April 1, 2016 – March 31, 2017) <ul style="list-style-type: none"> ○ Promotes a bundled service unit for the uninsured, including <ul style="list-style-type: none"> ▪ PAM Administration ▪ Connection to primary care providers and/or insurance

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	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Screening for care management needs and referral if indicated ▪ Tracking of program activities ○ Linkage to care management will be included as Health-Home At-Risk ramps up • Hotspots were identified based on zip codes in Community Needs Assessment and targeted for Project 11 activities • Ongoing implementation will include continuous learning about working with CBOs and engaging hard-to-reach patients • Next steps in implementation design include: <ul style="list-style-type: none"> ○ Develop methodology and process to estimate primary care access across the OneCity Health network ○ Identify and improve scheduling systems for primary care services and for community-based services ○ Develop approach to measuring ‘success’ in linkage to primary care, ideally measuring if scheduled appointments are kept ○ Identify solutions to reliably track the needs of uninsured populations and the services provided to them
5. Next steps	<ul style="list-style-type: none"> • <i>Upcoming agenda topics:</i> <ul style="list-style-type: none"> ○ “Integrated delivery system” update ○ Implementation strategies for next phase of ED Care Triage and for psychiatric care transitions • Next committee meeting: September 21, 2016