OneCity Health Care Models Committee

Meeting Summary

September 19, 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 (by phone)
- Dave Chokshi
- Elizabeth Dubois
- Esther Moas (by phone)
- Jack Dehovitz
- Joseph Masci (by phone)
- Lauren Johnston
- Oxiris Barbot
- Robert Fallaice
- Rose Madden-Baer
- Sudha Acharya (by phone)

Not in Attendance:

- Chris Norwood
- Christina Jenkins, OneCity Health CEO
- Dona Green
- Eric Manheimer
- Gary Belkin
- Hillel Hirshbein
- Moira Dolan (Observer)
- Pamela Sass
- Talya Schwartz

Committee Support:

- Dona Iversen
- Isaac Reyes
- Lisa Greenstein
- Madeline Rivera
- Samantha Kumar

Agenda Item	Notes
1. Review and Approval of Minutes	• August 10, 2016 meeting minutes *approved*
2. OneCity Health Updates	• Implementation workgroup updates ○ Cardiovascular disease management workgroup held in early September ○ Homelessness workgroup scheduled for late September

Agenda Item	Notes
	○ Asthma and care management workgroups seeking participants
3. Care Model: ED Care Management	Presentation of ED Care Management Care Model by Anna Flattau, OneCity Health Chief Clinical Officer *Key discussion items included:* • Focus of the care model is the implementation of care management teams in the adult medical ED setting ○ Phased implementation of the ED Care Triage care model ○ This care model further describes Phase 2: Linkage to Care Management and Phase 3: Short-term Transitions of ED Care Triage ○ Phase 2: Identify patients who qualify for and would benefit from existing care management programs, including Health Home and Health Home At-Risk ○ Phase 3: Provide targeted short-term care management services for ED patients at high risk of hospitalization or repeat ED visits • Standard approach to ED care management ○ Identify high-risk patients through referrals from ED clinical team ○ Transition team provides multidisciplinary care management within the ED and for up to 14 days after discharge ○ Integration and/or co-location with Health Home and home care services ○ Standard best practices for addressing complex patient needs (e.g. homelessness, substance abuse, palliative care and hospice evaluations, and chronic pain) • 24/7 staffing will likely not be possible in early implementation ○ Align shifts with peak times at each ED and then explore staffing solutions for non-peak times • ED transition team composition: ○ Care manager (licensed as registered nurse) ○ Social worker ○ Transitions assistant (non-clinical worker) ○ Pharmacist • Transition team services in the ED ○ Encourage appropriate referrals through case review and design community-based alternatives to admission ○ Assess referrals and identify needs after discharge for 14 day follow up period

Agenda Item	Notes
	○ Care coordination with primary care and other community providers, including warm handoffs to Health Home and home care ○ Linkage to needed services in the community (e.g. transportation) ○ Support culturally and linguistically competent communication • Transition team work after discharge (up to 14 days) ○ All enrolled patients will receive a follow-up call within 48 hours of discharge ○ Additional follow-up with medications, caregivers, and linkages to medical care and social services as needed, depending on the assessment performed in the ED • Currently model does not include redirection of patients from the ED to the outpatient setting; this can be revisited in the future • Patient scenarios reviewed by ED care management workgroup ○ Other patient scenarios to consider: alcohol withdrawal with alternatives to inpatient detox, opioid withdrawal with support for home withdrawals, and obese patients over 300 pounds *Discussion by the Committee included the following comments:* • Slide 5 – co-location is ideal but allow for creative solutions to space constraints to enable easy access and a warm handoff ○ Rent space nearby ○ Sit in waiting rooms and swing into vacant rooms when appropriate ○ Mobile computers, kiosks and phones • Define points of contact for both the patient and primary care provider for follow-up after discharge • Role of geographic, cultural and language specific community-based navigation to engage patients after discharge • ED teams will need to be engaged and educated to utilize care management transitions teams and to obtain buy-in to address the pressures of cycle time • Team member roles in ED care management: ○ Communicate clearly that roles are functions and not job titles ○ Home visits by nurses need to be consistent with regulatory requirements ○ Social worker can also be involved with self-management support

Agenda Item	Notes
	○ "Registered nurse" is a job title at NYC H+H, consider a new name for this team member to communicate clearly that this is a functional role • 2 additional roles to consider: ○ Prescriber role to support the transition into primary care ▪ A nurse practitioner can bridge the gap (e.g. medication reconciliation, abnormal labs, prescription adjustments) for the time period between discharge and follow-up outpatient appointment, when a continuity provider may not be available ○ Contact person for patients/ caregivers/ providers after discharge ▪ Availability from 9am to 5pm to liaise with primary care ▪ Would be useful to have a single phone number for primary care teams to call about pending labs, imaging and prescriptions *Decisions made:* • Motion passed to recommend ED Care Management Model to Executive Committee *Follow up items:* • Care Model to be edited and reflect discussion items above and distributed to Committee
4. Implementation Strategy Update: Adaptation of Care Transitions to Psychiatric Settings	Presentation of Adaptation of Care Transitions Implementation Strategy to Psychiatric Settings by Anna Flattau, OneCity Health Chief Clinical Officer *Key discussion items included:* • Further definition of the implementation strategy for transitions of care initiatives for patients in psychiatric settings • Psychiatric Care Transitions workgroup met in July; additional workgroups to be convened on managing homelessness and substance abuse within care transitions initiatives • A pilot of care transitions within the King's county inpatient psychiatric service informed the evolution of implementation strategy • Implementation strategy evolved from approached in the medical setting in key areas:

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	○ All psychiatric inpatient patients are assessed by the transitions team ○ Either a registered nurse or social worker is the team leader ○ The anticipated caseload (20-25) is smaller due to more intense patient needs ○ Patient needs are similar in the Comprehensive Psychiatric Emergency Program (CPEP) setting as in the inpatient setting, so the same care model will be used ○ Team structure will be further supported by peers for mental health and substance abuse • Possible future enhancements to implementation strategy: ○ Substance abuse consult service ○ Formalized linkages or embedded Transition Management Assistants in specific shelters ○ Pharmacist support, including the support of chronic medical needs • Anticipated challenges: ○ Substance abuse, homelessness, and criminal justice issues are major obstacles ○ Limitations in coordination with community-based services ○ High rate of refusal of transition management services ○ Managing the chronic medical needs of patients presenting in psychiatric settings
5. Next Steps	• Next committee meeting: November 3 • Upcoming agenda topics: ○ Population approach to palliative care ○ Updates on MHSA and IDS initiatives