OneCity Health Care Models Committee

Meeting Summary

September 21, 2015
199 Water Street, 31st Floor, New York, NY
4:00 – 6:00 PM

In Attendance:

- Joseph Masci, Committee Chair
- Christina Jenkins, CEO OneCity Health Services
- Anna Flattau, OneCity Health Chief Clinical Officer
- Rose Madden-Baer
- Dave Chokshi
- Cecilia Jordan
- Esther Moas
- Robert Faillace
- Hillel Hirshbein
- Gary Belkin
- Chris Norwood
- Sudha Acharya
- Elizabeth Dubois
- Eric Manheimer
- Jack Dehovitz
- Pamela Sass
- *Not in attendance:*
  - *Lauren Johnston*
  - *Dona Green*
- *Committee Support:*
  - *David Rosales*

Item	Notes
1. Review and Approval of Minutes	• July 29th meeting minutes *approved*
2. OneCity Health Updates	• Update provided by OneCity Health Chief Clinical Officer, Anna Flattau: ○ Ongoing hub-level partner engagement process involving series of conversations with partners leading to initial contracting ○ Project planning process, including early project deployment activities around Project 11, Asthma, and cross-project integration for primary care partners *Related questions/topics discussed as a group:* • Magnitude of PPS network primary care capacity shortage relative to anticipated demand • Opportunities to impact training capacity and approach for medical professionals to better align with DSRIP goals *Follow-up items* • OneCity Health Services to prepare presentation for future Care Models

Item	Notes
	Committee meeting describing understanding of current state primary care access and capacity within the PPS network
3. Recap of approach to metric selection and workgroup process	Rationale and approach to initial metric selection described by Anna Flattau: • *Objective:* For the full committee to recommend 3-5 measures relevant to each partner type to monitor their progress in the early stages of implementation (~12 months) • *Rationale:* o By achieving these measures, each partner will be better-positioned to achieve transformation goals Charter revisions reviewed o Our recommendations will be formally approved by the Executive Committee for use in overall program management at the partner level o A subset of these measures may be used in the contracting process to determine fulfillment of responsibilities • *Approach.* Workgroups were convened after the July 29th Commmittee meeting to propose measures for major partner types: o Clinical workgroup: primary care, acute care, behavioral health o Community-based workgroup: CBOs providing social services vs. clinical services o (Overlap area: primary care) • *Criteria/Considerations for metric selection.* Initial measures were intended to reflect: o Early foundational activities to enable DSRIP goals and achievement of PPS milestones o Tasks that can be done by the partners, independent of other PPS resources with longer lead times (eg, IT support, analytics, care management platform) o Unique skills contributed by various types of organizations o Clinical interdependencies (eg, screening for behavioral health disorders in primary care setting will be challenging if treatment options are still inadequate) o Initial measures should: o Be achievable relatively soon after associated funding is provided (eg, hiring, curriculum development) o Set the PPS up for future implementation stages
4. Review of proposed early-stage metrics for	• Review of metrics proposed by sub-workgroups led by Anna Flattau

Item	Notes

recommendation to the Executive Committee	• Key discussion items included:
	  ○ Feasibility of metrics dependent on sufficient primary care access
	  ○ Role of the Patient Activation Measure (PAM) in the the NYS DSRIP program
	  ○ The role that the broader care model development process will play in further defining several concepts cited in the proposed metrics (eg, criteria that define a 'high-risk' patient, common standards around patient self-management goals)
	
	• ***Decisions made:***
	  ○ Motion seconded and passed to recommend metrics to Executive Committee upon incorporation of specific edits proposed during discussion
	  ○ Unanimous vote by committee to recommend metrics to Executive Committee upon incorporation of specific edits proposed during discussion.
	  ○ Permission granted by committee to move forward with recommended metrics with understanding that in future committee meeting(s), OneCity Health Services will present proposed data definitions and additional detail required to operationalize the recommended metrics
	
	Recommended metrics by partner type, with proposed edits incorporated:
	
	○ *Acute-Care Hospitals:*
	  1. Use of screening tool, including psychosocial and clinical factors, to identify patients at high risk of readmission.
	  2. All discharge plans ("care transitions plans") should include in its core elements a primary care appointment date with contact information; and this plan should be provided to the primary care practitioner prior to or during the patient's follow-up appointment.
	  3. Process in place to screen for and refer high-risk patients in need of care management, including Health-Home eligible patients.
	
	○ *Behavioral Health Outpatient:*
	  1. Process in place to identify patients without primary care visit in prior year and link them to primary care provider.
	  2. Staff completed training in PAM administration.
	  3. Process in place to screen for and refer high-risk patients in need of care management, including Health-Home eligible patients.
	  4. Demonstrate adequate engagement by providers in

Item	Notes
	learning and technical assistance activities provided by OneCity Health. ○ *Primary Care:* 1. Complete written plan and timeline for achieving 2014 level 3 PCMH certification. 2. Offer appointments for patients discharged from hospital or ER visits within 7 days who are deemed by their clinical provider as requiring priority follow-up. 3. Demonstrate a plan for 24-hour patient telephone access with interlocutor linked to medical record. 4. Process in place to screen for and refer high-risk patients in need of care management, including Health-Home eligible patients, and to track those referrals in a format compatible with future registry development. 5. Demonstrate screening for cardiovascular risk with triggering of related interventions (aspirin use, statin use, self-management goals documented, smoking cessation); demonstrate documentation in format compatible with future development of a registry. 6. Written communication displayed and/or provided in written form to patients, in all major languages spoken by the patient population, explaining the practice's services and its work towards PCMH L3 standards. 7. Demonstrate adequate engagement by providers in learning and technical assistance activities provided by OneCity Health. ○ *Service-providing CBOs (non-clinical)* 1. Staff completed training in PAM administration and met goals for PAM administration when specified in contract. 2. Process in place to identify patients who lack primary care and link them to primary care resources. 3. Process in place for referral to certified insurance counselors for uninsured patients, and to counsel on care options for uninsurable patients. 4. Community-based workers hired and trained when specified in contract.
5. Next steps	• *Upcoming agenda topics:* ○ Care models for early-deployment projects, including Project 11, Asthma ○ Presentation on current state primary care capacity/access ○ Data definitions and additional detail required to operationalize partner metrics • Next committee meeting: October 26