NewYork-Presbyterian Queens

NYP Queens DSRIP PPS –Cardiovascular Committee

Meeting Title:	**NYP Queens DSRIP Cardiovascular Project**	**Meeting Date:**	June 6, 2017
Facilitator(s):	M. D'Urso/ M. Cartmell,	**Meeting Time:**	9:30 AM – 10:30 AM
Conference Line:	877-594-8353	**Code:**	79706143#
Location:	NYP/Q 56-45 Main Street; Radiation Oncology Room		

Meeting Purpose:

DSRIP Implementation – Project Requirements Implementation

#	Topic	Responsible Person	Document
1.	Welcome & Purpose	M. D'Urso, RN	-
2.	Approve Meeting Minutes – 05/16/17	M. D'Urso, RN	NYPQ PPS Cardio Meeting Minutes 05 1
3.	**Future Deliverables: ALL DUE DY3Q4** ***Milestone# 2:*** Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3. ***Metric# 2.1***: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. ***Minimum Documentation:*** QE agreements **Current Status:** Cory to provide QE agreement and connectivity status for PCPs in the project ***Metric# 2.2***: PPS uses alerts and secure messaging functionality. ***Minimum Documentation:*** EHR vendor documentation; screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging.	M. D'Urso, RN/ S.Choudhury	Updated_PCP_master Timeline.xlsx

	Next Steps: • Marlon will compile screenshots to show each Cardio project partner is using alerts and secure messaging functionality • Cureatr training? Was there a training for all partners or individual training? We need training sign in sheets and training materials for cureatr ***Milestone# 8:*** Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment. ***Metric 8.1:*** All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments. ***Minimum Documentation:*** Policies and procedures related to blood pressure checks; Roster of patients, by PCP practice, who have received follow-up blood pressure checks. **Current Status:** PMO has reached out to the partners for policy/procedure that show that they provide follow up blood pressure checks without copayment or advanced appointments. If any partner has roster, we will accept that as well. ***Milestone# 10:*** Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit. ***Metric # 10.1:*** PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension. ***Minimum Documentation:*** Risk assessment tool documentation; risk assessment screenshots, Patient stratification output; Documented protocols for patient follow-up. **Current Status:** Marlon Hay is working with Dr. Dalal to create patient stratification registry in Athena, that will then be shared with all other partners so they can build	M. D'Urso, RN/ S.Choudhury	 Hypertension AHA.Undetected Hyp

	something similar in their eMR ***Metric# 10.2:*** PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients. ***Minimum Documentation:*** Vendor System Documentation; other Sources demonstrating implementation of the system. ***Metric# 10.3:*** PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling. ***Minimum Documentation:*** List of training dates along with number of staff trained; Written training materials. ***Milestone #12***: Document patient driven self-management goals in the medical record and review with patients at each visit. ***Metric# 12.1:*** Self-management goals are documented in the clinical record. ***Minimum Documentation:*** Documentation of self-audit of de- identified medical records over project timeframe demonstrating self-management goals documented in the clinical record. **Current Status:** PMO reached out to Brightpoint and CHN to find out about their practices in self-audit, if any, for self-management goals documentation in eMR, and if so, what's the frequency. ***Metric# 12.2:*** PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals. ***Minimum Documentation*** : List of training dates along with number of staff trained; written training materials. **Next Steps:** How as PPS can we best make sure all staff in the partner sites are trained in this? We did a refresher webex in March. Sign in sheets from each partner for the trainings		

	Milestone #13: Follow up with referrals to community based programs to document participation and behavioral and health status changes. ***Metric # 13.1***: PPS has developed referral and follow-up process and adheres to process. ***Minimum Documentation***: Policies and Procedures of referral process including warm transfer protocols. **Current Status:** PMO reached out to Brightpoint and CHN to see if they have policy/procedure as to how they refer patients to community based programs and follow up process for that? Are there any agreements in place with those community based organizations? If so, are they valid? ***Metric # 13.2:*** PPS provides periodic training to staff on warm referral and follow-up process. Minimum Documentation: List of training dates along with number of staff trained; written training materials. ***Metric # 13.3:*** Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations. ***Minimum Documentation***: Written attestation or evidence of agreement; Documentation of process and workflow including responsible resources at each stage of the workflow **Current Status:** PMO reached out to Brightpoint and CHN to see if they have policy/procedure as to how they refer patients to community based programs and follow up process for that? Are there any agreements in place with those community based organizations? If so, are they valid?		

	Milestone #17: Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases. ***Metric# 17.1:*** If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities. ***Minimum Documentation***: REAL dataset; documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; list of training dates along with number of staff trained; periodic self-audit reports and recommendations. **Next Steps**: This will be incorporated in the Rapid Cycle Evaluation process and Clinical Integration Quality Committee meeting discussions ***Metric# 17.2:*** If applicable, PPS has established linkages to health homes for targeted patient populations. ***Minimum Documentation***: Written attestation or evidence of agreement with community partners; documentation of process and workflow including responsible resources at each stage of the workflow; list of training dates along with number of staff trained; written training materials **Current Status:** Health Home trainings with most partner sites completed. Sadia and Coleen completed train the trainer for QCCP Health Home and will be going to some of the remaining partners and train on heath home and referral process ***Metric# 17.3:*** If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations. ***Minimum Documentation***: Written attestation or evidence of agreement with community partners; list of training dates along with number of staff trained; written training materials		

	Next Steps: • Evaluate Stanford Model (see attached document) http://patienteducation.stanford.edu/programs/cdsmp.html ***Chronic Disease Self -management Program (CDSMP)*** • 6 week workshop held weekly at community sites or online • Facilitated by highly trained lay leaders • Covers several self-management skills to help patients with 3 main self-management tasks • Evidence based • Self-efficacy because knowledge not enough! • Self-directed learning • Based on patient's perception of the problem • 10-15 participants meet weekly for 2 ½ hour sessions for 6 weeks • Community locations or online		 Stanford Model Chronic Disease.pdf
4.	Adjourn	-	-

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Project 3.b.i –Cardiovascular Project

Project Committee Meeting

June 6th 2017 9:30am –10:30am EST

Attendees: Jalen Faison (NYP/Q), Coleen Dunkley (NYP/Q), Maria D'urso (NYP/Q), Robert Crupi (NYP/Q), Sadia Choudhury (NYP/Q) Marlon Hay (NYP/Q), Laquan McConnell (NYP/Q), Margaret Cartmell (NYP/Q),

Topic	Discussion	Actions
1. Agenda:	• Welcome & Purpose • Meeting minutes Approval • Project Deliverables DY3Q4	• N/A
2. Meeting minutes: M. D'Urso	• Committee reviewed meeting minutes from 05/16/17 meeting.	• Committee voted to unanimously approve the meeting minutes.
3. Future Deliverables M. D'Urso, RN/ S. Choudhury	Future Deliverables**: ALL DUE DY3Q4** ***Milestone# 2:*** Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3. ***Metric# 2.1***: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. ***Minimum Documentation:*** QE agreements ***Current Status:*** There is a total of 15 outstanding partners who are not connected to the RHIO. 3 participation agreements, 14 partners who are connected to the RHIO.	• Cory will engage all PCP partners and connect them to the RHIO. • Cory will provide QE agreements and connectivity status for PCPs in the project. • The PPS will need to provide documentation that shows each partner is sharing data.

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Topic	Discussion	Actions
	Metric# 2.2: PPS uses alerts and secure messaging functionality. ***Minimum Documentation:*** EHR vendor documentation; screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging. ***Milestone# 8:*** Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment. ***Metric 8.1:*** All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments. ***Minimum Documentation:*** Policies and procedures related to blood pressure checks; Roster of patients, by PCP practice, who have received follow-up blood pressure checks. ***Current Status:*** PMO has been in communication with partners for Policy/procedure that show that they provide follow up blood pressure checks without copayment or advanced appointments. If any partner has a roster, the PMO will accept that as well. ***Milestone# 10:*** Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit. ***Metric # 10.1:*** PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension. ***Current Status:*** Marlon and Dr. Dalal created the first draft of the patient stratification system. ***Minimum Documentation:*** Risk assessment tool documentation; risk assessment screenshots, Patient	• Marlon will compile screenshots to show each Cardio partner is using alerts and secure messaging functionality. • The PMO will collect policy/procedure or redacted roster from each facility. • Jalen will create a tracker to track the progress of each facility. • Marlon Hay is working with Dr. Dalal to create a patient stratification registry in Athena. The next step is to have the system trigger alerts.

Topic	Discussion	Actions
	stratification output; Documented protocols for patient follow-up. ***Metric# 10.2:*** PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients. ***Minimum Documentation:*** Vendor System Documentation; other Sources demonstrating implementation of the system. ***Metric# 10.3:*** PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling. ***Minimum Documentation:*** List of training dates along with number of staff trained; Written training materials.	• Marlon or the PMO will compile screenshots to show each partner is using an automated scheduling system to facilitate scheduling of targeted hypertension patients. • PMO will train partners to ensure effective patient identification and hypertension visit scheduling. • PMO will collect the list of training dates along with the number of staff trained and written training materials.
	Milestone #12: Document patient driven self-management goals in the medical record and review with patients at each visit. ***Metric# 12.1:*** Self-management goals are documented in the clinical record. ***Minimum Documentation:*** Documentation of self-audit of de- identified medical records over project timeframe demonstrating self-management goals documented in the clinical record. ***Current Status:*** PMO reached out to Brightpoint and CHN to find out about their practices in self-audit, for self-management goals in EMR.	• The PMO will collect documentation or de-identified medical records that demonstrate self-management goals documented in the clinical record.

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Topic	Discussion	Actions
	Metric# 12.2: PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals. ***Current Status:*** The PMO conducted a WebEx refresher training in March. Sign in sheets from each partner were collected. ***Minimum Documentation***: List of training dates along with number of staff trained; written training materials. ***Milestone #13:*** Follow up with referrals to community based programs to document participation and behavioral and health status changes. ***Metric # 13.1***: PPS has developed referral and follow-up process and adheres to process. ***Minimum Documentation***: Policies and Procedures of referral process including warm transfer protocols. ***Current Status:*** PMO reached out to Bright Point and CHN to see is they have any policy/procedure as to how they refer patients to community based programs and follow up process. ***Metric # 13.2:*** PPS provides periodic training to staff on warm referral and follow-up process. ***Minimum Documentation:*** List of training dates along with number of staff trained; written training materials. ***Current Status:*** PMO reached out to Brightpoint and CHN to see if they have any policy/procedure as to how they refer patients to community based programs. ***Metric # 13.3:*** Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	• Once the PMO standardizes a process for self-management goals the PMO will train partners. • PMO will collect policy/procedure from partners on their referral process including the warm transfer protocols. • PPS will train partners on the referral process and follow-ups. • The PMO will create a tracker and collect agreements. This will also include documentation of the process and workflows.

Topic	Discussion	Actions
	Minimum Documentation: Written attestation or evidence of agreement; Documentation of process and workflow including responsible resources at each stage of the workflow. ***Milestone # 17:*** Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases. ***Metric# 17.1:*** If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities. ***Minimum Documentation***: REAL dataset; documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; list of training dates along with number of staff trained; periodic self-audit reports and recommendations. ***Metric# 17.2:*** If applicable, PPS has established linkages to health homes for targeted patient populations. ***Minimum Documentation***: Written attestation or evidence of agreement with community partners; documentation of process and workflow including responsible resources at each stage of the workflow; list of training dates along with number of staff trained; written training materials ***Current Status:*** Health Home trainings with majority of the partner sites complete. Sadia and Coleen completed train the trainer for QCCP Health Home.	• This milestone will be incorporated in the Rapid Cycle evaluation process and Clinical Integration Quality Committee meeting discussion. • Coleen will train the remaining partners on the Health Home referral process.

Topic	Discussion	Actions
	Metric# 17.3: If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations. ***Minimum Documentation***: Written attestation or evidence of agreement with community partners; list of training dates along with number of staff trained; written training materials ***Chronic Disease Self -management Program (CDSMP)*** • 6-week workshop held weekly at community sites or online • Facilitated by highly trained lay leaders • Covers several self-management skills to help patients with 3 main self-management tasks • Evidence based • Self-efficacy because knowledge not enough! • Self-directed learning • Based on patient's perception of the problem • 10-15 participants meet weekly for 2 ½ hour sessions for 6 weeks • Community locations or online	• The PMO will evaluate more information about the Stanford model. • N/A
4. Adjourn		