NewYork-Presbyterian Queens

NYP Queens DSRIP PPS –Cardiovascular Committee

Meeting Title:	NYP Queens DSRIP Cardiovascular Project	Meeting Date:	December 5th , 2017
Facilitator(s):	M. D'Urso	Meeting Time:	10:30 AM – 11:00 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-11/07/2017	M. D'Urso, RN	Cardio Meeting Minutes 11.07.17.do
3.	**Rapid Cycle Performance Measures**	K. Fung/ D. Notarnicola	Cardio - MY3 Month 9 of 12 Resul
4.	**Cardiovascular WebEx Training on Wednesday, December 6th, from 2:00 PM-3:00 PM.** The Following topics will be covered: • Patient identification and hypertension visit Scheduling. • Documentation of self-management goals • Warm referral and follow up process **Today will be the last day to submit the registration template to the PMO.**	Jalen Faison	Registration Template.xlsx
5.	**DY3 Q4 Deliverables: (3.31.18)** **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:** 10 partners are not connected to the RHIO. The PMO has 5 partners connected to the RHIO.	M. D'Urso, RN	DY3. Q4 Deliverable Tracker.xlsx

	Metric 2.2: PPS use alerts and secure messaging functionality. ***Minimum Documentation:*** HER 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. **Current Status:** 8 partners are using direct mail and secured messaging functionality. **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. **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:** Vendor system documentation; sources demonstrating implementation of the system. ***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. **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.		Hypertension BP checks.pdf

	Minimum Documentation: Policies and Procedures of referral process including warm transfer protocols. **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. ***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 17.2:*** 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:*** 6 remaining partners need to be trained by the PMO on Health Homes.		warm handoff3.b.pdf
6.	Discussion & Questions	Team	-
7.	Adjourn	Team	-

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Project 3.b.i –Cardiovascular Project

Project Committee Meeting

December 5th 10:30 AM-11:00 AM ET

Attendees: C. Dunkley (NYPQ), L. McConnell (NYPQ), K. Fung (NYPQ), D. Notarnicola (NYPQ), A. Bodykova (NY Medical), S. William (Brightpoint Health), P. Cartmell (NYPQ), M. D'Urso) (NYPQ), S. Schauman (NYPQ), J. Faison (NYPQ)

Topic	Discussion	Actions
1. Agenda:	• Welcome & Purpose • Approve Meeting Minutes • Rapid Cycle Performance Measures • Cardiovascular WebEx Training • DY3 Q4 Deliverables • Discussion & Questions • Adjourn	• N/A
2. Approve Meeting Minutes M. D'Urso, RN	• Committee reviewed meeting minutes from **11.07.2017**	• The committee voted unanimously approve the meeting minutes.
3. Rapid Cycle Performance Measures K. Fung/ D. Notarnicola	• K. Fung reviewed 4 out of the 17 metrics associated with the cardiovascular project. The measures include: PQI8 Heart Failure, Admission Rate, Prevention Quality Indicator, Statin Therapy for Patients with Cardiovascular Disease- Received Statin Therapy, and Statin Therapy for Patients with Cardiovascular Disease- Statin Adherence 80%.	• The PMO will use Quality data to start action planning to improve clinical outcomes.

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Topic	Discussion	Actions
	• The PPS will be moving from a pay for reporting system to a pay for performance system. PPS partners will receive incentives based on clinical outcomes. • The PMO can potentially earn **$141, 713.59** if measurements year 3 results are all met. • The PMO can potentially loose **$87, 662.86** if measurement year 3 results are not met. • Subtracting the potential total of **$141,713.59** from the metrics not met **$87.662.86** the adjusted total is **$54,050.73.**	
4. Cardiovascular WebEx Training J. Faison	**The Cardiovascular WebEx Training will take place on Wednesday, December 6th, from 2:00 PM-3:00 PM.** The Following topics will be covered: • Patient identification and hypertension visit Scheduling. • Documentation of self-management goals • Warm referral and follow up process Monday, December 5th will be the last day the PMO will be accepting registration templates.	• Please register for the webinar by the end of the Day.
5. DY3 Q4 Deliverables: (3.31.17) M. D'Urso, RN	**DY3 Q4 Deliverables: (3.31.18)** **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.	• The PMO will continue to collect QE agreements from partners.

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Topic	Discussion	Actions
	Minimum Documentation: QE Agreements • All partners have signed QE agreements. • The RHIO will enhance care coordination once all partners are connected to the RHIO. ***Metric 2.2:*** PPS use alerts and secure messaging functionality. ***Minimum Documentation:*** EMR 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. • LaQuan McConnell IT Site Coordinator will continue to work with PPS partners to collect screen shots of alerts and secured messaging functionality. **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. • In order to meet this milestone, PPS partners have the option to either submit a roster of patients who has received follow-up blood pressure checks or a related policy and procedure document.	• PPS partners please reach out to Corey if you have any questions regarding the RHIO. • The PMO will continue to collect screen shots from partners to ensure that they are receiving alerts and using direct mail. • The PMO will continue to collect screen shots from partners to verify they are receiving alerts and using direct messaging.

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Topic	Discussion	Actions
	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:** Vendor system documentation; sources demonstrating implementation of the system. • The PMO identified patients who have repeated elevated blood pressure readings by querying quarterly reports. ***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. • The PPS will implement a semi-automated scheduling system to target patients with hypertension. • The PMO is working with internal IT resources to develop a patient stratification system to identify and generate monthly list of patients who have multiple high blood pressure readings but no diagnosis of hypertension. The list of patients will be sent to a coordinator to schedule a follow up visit for the patient. **Milestone #13:** Follow up with referrals to community based programs to document participation and behavioral and health status changes.	• The PMO will create a workflow to indicate how the stratification system is used. • The PMO is scheduled to have this metric completed before March of 2018. • The PMO is working with clinical leads to project a role out date.

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Topic	Discussion	Actions
	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. **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. • The PPS will create an MOU to work with Community Based Organizations. ***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 17.2:*** 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.	• The PMO will continue to collect policies and procedures of referral process including warm transfer protocols. • The PMO will create a workflow that documents how the PPS communicates with CBO's.

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Topic	Discussion	Actions
	• The DSRIP analytics team created hot spotting data to identify high prevalent areas in queens.	• The PMO will use the real data set to identify high risk neighborhoods and train PPS partners on health homes.
6. Discussion & Questions		-
7. Adjourn		-