NewYork-Presbyterian Queens

NYP Queens DSRIP PPS –Cardiovascular Committee

Meeting Title:	NYP Queens DSRIP Cardiovascular Project	Meeting Date:	August 1, 2017
Facilitator(s):	M. D'Urso/ M. Cartmell,	Meeting Time:	10:00 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 – 06/06/17	M. D'Urso, RN	NYPQ PPS Cardio Meeting Min 06 06 1
3.	**Actively Engaged Patients:** • The PMO has met the target number for actively engaged patients for DY3. Q1, which was 463 patients. • The target number for DY3. Q2 for actively engaged patients is 726. This metric is due at the end of September. **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:*** 15 outstanding partners are not connected to the RHIO. 3 participation agreements, 14 partners who are connected to the RHIO.	K. Fung M. D'urso, RN	

	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. ***Next Steps*** • Corey will engage all PCP partners and connect them to the RHIO. • Cory will provide QE agreements and connectivity status for PCP partners in the project. • The PPs will need to provide documentation that shows each partner is actively sharing data. **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. ***Next Steps*** Marlon will compile screen shots to show that each cardio partner is using alerts and secure messing 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.	M. D'urso, RN/	

Current Status: The PMO has been in communication with partners for policies/procedures that show that they provide follow up blood pressure check without copayment or advanced appointments.

Next Steps

- The PMO will collect policies/procedures or redacted roster from each facility.
- Jalen will create a tracker to track the progress of each facility.

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; other Sources demonstrating implementation of the system.

Current Status: Marlon and Dr. Dalal created the first draft of the patient stratification system. Once the stratification system is complete, partners can build something similar into their EMR system.

Next Steps

- Marlon is working with Dr. Dalal on the patient stratification registry in Athena. The next step is to have the system triggering alerts.

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. ***Next Steps:*** • The PMO will compile screenshots to show that each partner is using an automated scheduling system to facilitate scheduling of targeted hypertension patients. • The PMO will train partners to ensure effective patient identification and hypertension visit scheduling. • The PMO will collect the list of training dates along with the number of staff trained. ***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. ***Next Steps:*** • The PMO will collect documentation or de-identified medical records that demonstrate self-management goals documented in the medical record. ***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 ***Current Status:*** The PMO conducted a WebEx refresher training in March. Sign in sheets from each partner were collected. ***Next Steps:*** • Once the PMO standardizes a process for self-management goals, the PMO will train partners. ***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. ***Next Steps:*** • PMO will collect policy/procedure from partners on their referral process including the warm transfer protocols. ***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. ***Next Steps:*** • PPS will train partners on the referral process and follow-ups. ***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.		

	Next Steps: • The PMO will create a tracker and collect agreements. This will also include documentation of process and workflows. ***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 milestone will be incorporated in the Rapid Cycle evaluation process and Clinical Integration Quality Committee meeting discussion. ***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.		

	Next Steps: • Coleen will train the remaining partners on the Health Home 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:*** • The PMO will evaluate more information about the Stanford model.		
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Project 3.b.i –Cardiovascular Project

Project Committee Meeting

August 1st 10:00-11:00 AM ET

Attendees: J. Faison (NYPQ), K. Fung (NYPQ), S. Schauman (NYPQ), M. Hay (NYPQ), C. McConnell (NYPQ), R. Crupi (NYPQ), P. Cartmell (NYPQ), M. D'urso (NYPQ) S. William (Brightpoint)

Topic	Discussion	Actions
1. Agenda:	• Welcome & Purpose • Meeting Minutes Approval • Actively Engaged Patients • Meeting minutes Approval • Project Deliverables DY3Q4	• N/A
2. Approve Meeting Minutes	• Committee reviewed meeting minutes from 06/06/17 meeting.	• Committee voted to unanimously approve the meeting minutes.
3. Engaged Patients	***Actively Engaged Patients:*** • The PMO exceeded the target number of actively engaged patients with 463 patients in DY3Q1. • The PMO has to have a cumulative of 726 actively engaged patients by DY3Q2. **(263 in total by the end of this quarter)**	• N/A
4. DY3Q4	***Project Deliverables DY3Q4:*** ***Millstone# 2:*** Ensure that all PPS safety net providers are actively connected to HER systems with local health information exchange and sharing health information among clinical partners, including direct mail, secured messaging, alerts and patient look up. ***Metric# 2.1:*** HER meets connectivity to RHIO's HIE and SHIN-NY requirements. ***Minimum Documentation:*** QE Agreements ***Metric# 2.2:*** PPS uses 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	• Jalen will create a template and aid Corey in tracking QE agreements. • The PMO will have all partners using direct mail, secured messaging and patient look up before the deadline of **DY3Q4**. • The PMO will create a PCP time line to engage partners and connect partners to the RHIO.

Topic	Discussion	Actions
	along with a number of staff trained in use of alerts and secure messaging. ***Next Steps*** • The PMO will collect screen shots of PPS partners using direct mail and secured messaging. • Once partners are connect to the RHIO, the PMO will train partners on how to use direct mail and secures messaging. • The PMO will collect training material, sign-in sheets and number of staff trained. _____ ***Milestone# 8:*** Provide opportunities for follow-up blood pressure check without a copayment or advanced appointment. ***Metric# 8.1:*** Primary care practices in the PPS must provide follow-up blood pressure checks without copayments 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:*** CHN has been the only partner to submit a policy that is related to 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:*** Risk assessment tool documentation; risk assessment screenshots, patient stratification output; documented protocols for patient follow up. ***Current Status:*** Dr. Dalal has developed the stratification system to trigger alerts for patients with elevated blood pressure but no diagnosis of hypertension.	• The PMO will work with partners to ensure that we are receiving accurate screen shots. • The PMO will communicate with partners bi-weekly to ensure each partner submits polices or procedure related to blood pressure checks. • N/A

Topic	Discussion	Actions
	Next Steps: • Once the stratification system is complete in Athena, the PPS can assist partners in building a stratification system in their EMR systems.	
	Metric# 10.2: PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients. ***Minimum Documentation:*** Vender 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 material. ***Next Steps:*** • The PMO will coordinate training dates to train partners on patient identification and hypertension visit scheduling. ***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:*** The PMO has to follow up with Brightpoint and CHN to find out about their practices in-self-audit and self-management goals in EMR. ***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	• The PMO will collect screenshots to ensure each partner is using an automated scheduling system. • The PMO will train PPS partners on how to identify and schedule visits with patients with hypertension. • The PMO will coordinate training dates along with the number of staff trained and written training materials. • The PMO will reach out to partners and find out about their best practices for self-management goals being documented in the patients' medical records.

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Topic	Discussion	Actions
	Current Status: The PMO conducted a WebEx refresher training in March. Sign in sheets from each partner were collected. Next Steps: • The PMO will coordinate training dates and collect sign in sheets and number of staff trained. ***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***- CHN submitted their referral process including warm transfer protocols. Next Steps: • The PMO will collect policies/procedures from partners on their referral process including warm transfer protocols. ***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. Next Steps: • Jalen will coordinate training dates and PPS partners will be trained on the warm referral and follow up process. ***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 PMO will conduct a refresher on self-management goals. • N/A • The PMO will work with the Committee and clinical leads to create a warm transfer and follow-up process. • The PMO will work with CBO's and create a workflow to show how the PPS is communicating with CBO's.

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Topic	Discussion	Actions
	Next Steps: • Jalen will schedule a meeting with CBO 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# 17.1:*** 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. Next Steps: • Jalen will coordinate with Coleen and have the remaining partners trained. ***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.	• The PMO will refer to the criteria and establish a data source. • This process will be implemented in the rapid cycle process. • Six partners need to be trained on the Health Home referral process. • The Committee discussed identifying one or two partners and train them on the Stanford Model.

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