NewYork-Presbyterian Queens

NYP Queens DSRIP PPS –Cardiovascular Committee

Meeting Title:	NYP Queens DSRIP Cardiovascular Project	Meeting Date:	September 5th, 2017
Facilitator(s):	M. D'Urso/ M. Cartmell,	Meeting Time:	10:30 AM – 11:30 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 – 08/01/2017	M. D'Urso, RN	Cardio Minutes 08-01-17.docx
3.	***Quality Data Review:*** • Rapid Cycle evaluation data review and action planning. ***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:*** 9 partners are not connected to the RHIO. The PMO collected 3 participation agreements and 6 partners are connected to the RHIO. **Next Steps:** • Corey will engage all PCP partners and connect them to the RHIO. • Jalen will collect QE agreements from Corey and create a template to track the status of each	K. Fung/ D. Notarnicola M. D'Urso, RN	Cardio Measures Overview - Final.pdf (Command Line) RHIO Tracker DY3 Q4 Cardio (2).xlsx

partner.

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:

- Once partners are connected to the RHIO, Healthix will train partners on how to use direct mail and secured messaging.
- The PMO will collect training material, sign-in sheets and document number of staff trained.
- The PMO will collect screen shots of emails between multiple parties to ensure each partner is using direct mail 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: CHN has been the only PPS partner to submit a policy/procedure that show that they provide follow up blood pressure check without copayment or advanced appointments.

Next Steps:

- The PMO will collect policies/procedures from each PPS partner.

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:** Dr. Dalal has to revise the data based on the criteria for the stratification system. Once the system is complete, partners can build a similar model into their EMR systems. **Next Steps:** • Jalen will work with Dr. Crupi to create a workflow to show how the stratification system is used. ***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. **Next Steps:** • The PMO will collect tickler screen shots from the interface analyst. • Once screen shots are collected, the PMO will draft an explanation of objectives. ***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:** • Jalen will coordinate with Dr. Crupi to select training dates to train partners on patient identification and hypertension visit scheduling.		

- The PMO will collect training material, sign in sheets and 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 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.

Next Steps:

- The PMO will create an executive summary that documents the auditing process.

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 training in March. Sign-in sheets from each partner was collected.

Next Steps:

- Jalen will coordinate with Dr. Crupi to schedule a refresher training for partners for self-management goals.

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 has been the only PPS partner to

	submit a policy/procedure 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 with Dr. Crupi; PPS partners will be trained on the warm referral and follow up process. • Training material, sign-in sheets and number of staff trained will be collected. ***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:** • Jalen will work with ACQ, QCCP and Elmcor and create a workflow to show how the PPS is communicating with CBO's. ***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. • The PMO will start researching how to retrieve the real data set. ***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. **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. ***Current Status:*** For strategic planning reasons the PPS		Health Home Tracker.xlsx

	leadership team has decided not to peruse the Stanford Model.		
4.	Adjourn	-	-

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Project 3.b.i –Cardiovascular Project

Project Committee Meeting

September 5th, 2017 10:30 AM ET

Attendees: J. Faison (NYPQ), L. McConnell (NYPQ), P. Cartmell (NYPQ), M. D'urso (NYPQ), A. Fishman (Americare NY), D. Notarnicola (NYPQ), S. Kalinowski (NYPQ), K. Fung (NYPQ), S. Williams (Brightpoint Health), A. Bodykova (NY Medical), R. Crupi, MD (NYPQ), A. Simmons (NYPQ), M. Hay (NYPQ), D. Cheslk (NYPQ),

Topic	Discussion	Actions
1. Agenda:	• Welcome & Purpose • Approve Meeting Minutes • Quality Data Review • Future Deliverables • Adjourn	• N/A
2. Approve Meeting Minutes	• Committee reviewed meeting minutes from 9/5/17 meeting.	• Committee voted to unanimously approve the meeting minutes.
3. Quality Data Review K. Fung/ D. Notarnicola	Rapid Cycle evaluation data review and action planning. • There are 17 metrics associated with the Rapid Cycle evaluation project. • The PMO will continue reviewing quality data and keep partners updated on the incentives associated with each metric. • The PMO will incorporate process improvement strategies using the quality data from the Rapid Cycle project.	• The PMO will email PPS partners the CAHPS survey to educate partners on survey questions that their patients are being asked.
4. DY3 Q4 (3.31.18) M.D'Urso	***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.	• The PMO will continue to collect QE Agreements.

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Topic	Discussion	Actions
	Metric# 2.1*:** EHR 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**:* 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:** The Medical Assistants in the NYPQ clinics are conducting follow up blood pressure checks.	• The PMO will collaborate with Healthix and connect PPS partners to the RHIO. • Once Partners are connected to the RHIO, Healthix will train partners on direct mail and secured messaging. • The PMO will continue to collect screen shots from partners to ensure that they are receiving alerts and using secured messaging. • The PMO will continue to collect policies and procedures 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.	• Dr. Dalal has to update the stratification system in Athena so that it can build reports.

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Topic	Discussion	Actions
	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. ***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 ***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 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. ***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 demonstrate how the stratification system is used. • The PMO will collect tickler screen shots from the interface analyst. • Once screen shots are collected, the PMO will draft an explanation of objectives. • The PMO will work with Dr. Crupi and create training material to have partners trained on patient identification and hypertension visit scheduling. The PMO will use WebEx or Health Stream as a training platform. • The PMO will continue to collect policies and procedures of referral

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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 # 13.2:*** 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. ***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.	process including transfer protocols. • The PMO will coordinate training dates with Dr. Crupi and train PPS partners trained on warm referral and follow up process. • The PMO will outline how the PPS is communicating with CBO's. • The PMO will develop hot spotting data to target high-risk neighborhoods. • The PMO will collect training material, sign-in sheets and number of staff trained.

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Topic	Discussion	Actions
	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.	• Coleen will train the remaining partners on the Health Home referral process.
5. Adjourn		