Meeting Title:	NYP Queens DSRIP Cardiovascular Project	Meeting Date:	October 18th , 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; Junior Conference Room		

Meeting Purpose:

DSRIP Implementation – Project Requirements Implementation

#	Topic	Responsible Person	Document
1.	Welcome & Purpose	M. D'Urso, RN	-
2.	Approve Meeting Minutes-**9.5.17**	M. D'Urso, RN	Cardio Meeting Minutes 09.05.17.do
3.	**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:** 9 partners are not connected to the RHIO. The PMO has 6 partners connected to the RHIO. ***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***:* 6 partners are using direct mail and secured	M. D'Urso, RN	DY3. Q4 Deliverable Tracker.xlsx

	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. ***Metric # 10.3:*** PPS provides periodic training to staff to ensure effective 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# 12.2***:* PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.		

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<td>**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.

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# 17.2: 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.</td>
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4.	**Adjourn**	-	-

NewYork-Presbyterian Queens PPS

Project 3.b.i –Cardiovascular Project

Project Committee Meeting

October 18, 2017 ET 10:30-11:30 AM

Attendees: C.McConnel (NYPQ), J. Faison (NYPQ), C. Dunkley (NYPQ), M. Hay (NYPQ), M. D'urso (NYPQ), M. Waxman (Self Help)

Topic	Discussion	Actions
1. Agenda:	• Welcome & Purpose • Approve Meeting Minutes • DY3 Q4 Deliverables **(3.31.18)** • Adjourn	• N/A
2. Approve Meeting Minutes	• Committee reviewed meeting minutes from 10.18.17	• Committee voted to unanimously approve the meeting minutes.
3. 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 • The PMO has 10 partners connected to the RHIO and 5 partners pending	• The PMO will continue to collect QE agreements.

Topic	Discussion	Actions
	QE Agreements. ***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:*** The PMO has 6 partners 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.	• Once partners are connected to the RHIO, Healthix will train partners on direct mail and secured messaging. • Corey will continue to collect screen shots from partners to ensure that they are receiving alerts and using direct mail. • The PMO will continue reaching out to partners to collect policies and procedures related to blood pressure checks.

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; sources demonstrating implementation of the system. • Dr. Dalal created a stratification system to identify the patients who have two or more occurrence of high blood pressures. ***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 PMO will work with Dr. Dalal to create an automated scheduling systems to target patients with hypertension. • Self Help has stationary Kais for patients to receive blood pressure checks. The BP results are then sent to an iPad and a member of the patients care team is notified. ***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.	• The PMO will create a workflow to indicate how the stratification system is used. • The PMO will collect screen shots of the automated scheduling system. • Once screen shots are collected, the PMO will create an executive summary of objectives. • The PMO will work with Dr. Crupi to coordinate training dates for partners to be trained on patient identification and hypertension visit scheduling.

Topic	Discussion	Actions
	Milestone #12*:* Document patient driven self-management goals in the medical record and review with patients at each visit. **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. **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. • The PMO will explore the option of collaboration with Self Help, to develop a referral and follow up process including warm transfer protocols. **Metric # 13.2:** PPS provides periodic training to staff on warm referral and follow-up process.	• The PMO will work with Dr. Crupi to coordinate training dates. • The PMO will continue to collect policies and procedures of referral process including warm transfer protocols. • The PMO will work with Dr. Crupi to coordinate training dates.

Topic	Discussion	Actions
	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 work flow. • The PMO will draft an MOU or an assentation 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. ***Current Status:*** 6 remaining partners need to be trained by the PMO on	• The PMO will create a workflow that outlines how the PPS is communicating with CBO's. • The PMO will collect training material, sign-in-sheets and number of staff trained.

Topic	Discussion	Actions
	Health Homes. • The PMO will create Hot Spotting Data to identify high prevalent areas in Queens. The PMO will then use the data to identify high risk neighborhoods and train providers on Health Homes.	
4. Adjourn		-