NYP Queens DSRIP PPS –Cardiovascular Committee

Meeting Title:	NYP Queens DSRIP Cardiovascular Project	Meeting Date:	January 29th, 2018
Facilitator(s):	M. D'Urso	Meeting Time:	1:30 PM-2:30 PM
Conference Line:	866-692-4538	Code:	26098085#
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-**12.04.2017**	M. D'Urso, RN	NYPQ DSRIP Cardiovasuclar Minu
3.	**Rapid Cycle Performance Measures**	K. Fung/ D. Notarnicola	3.b.i - MY3 Month 11 of 12 Measure Re
4.	**Actively Engaged Patients:** • Update on actively engaged patients	K. Fung	3.b.i - DY3 Q3 Actively Engaged Pa
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 DY3. **Metric 2.1:** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. **Minimum Documentation:** QE Agreements **Current Status:** Out of a total of 15 PPS partners, 7 are connected to the RHIO. ***Metric 2.2:*** PPS use alerts and secure messaging functionality. ***Minimum Documentation:*** EHR vendor documentation; screenshots or other evidence of use of alerts and secure	M. D'Urso, RN	DY3. Q4 Deliverable Tracker.xlsx

	messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging. **Current Status:** There are 10 PPS Partners that are using direct mails 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.		NYPQ-Hypertension BP checks.pdf
	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. **Minimum Documentation:** Policies and Procedures of referral process including warm transfer protocols.		NYPQ- Referral Tracking and Follow

	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.		
6.	Discussion & Questions	Team	-
7.	Adjourn	Team	-

New York-Presbyterian Queens PPS

Project 3.b.i –Cardiovascular Project

Project Committee Meeting

January 29th, 2018 1:30PM- 2:30 PM ET

Attendees: k. Fung (NYPQ), J. Faison (NYPQ), M. D'Urso (NYPQ), M. Hay (NYPQ), P. Cartmell (NYPQ), S. Williams (Brightpoint Health).

Topic	Discussion	Actions
1. Agenda:	• Welcome & Purpose • Approve Meeting Minutes • Rapid Cycle Performance Measures • Actively Engaged Patients • DY3 Q4 Deliverables • Discussion & Questions • Adjourn	• N/A
2. Approve Meeting Minutes M. D'Urso, RN	• Committee reviewed meeting minutes from **12.05.2017**	• The committee voted and unanimously approved the meeting minutes.
3. Rapid Cycle Performance Measures K. Fung	**Rapid Cycle Performance Measures** • K. Fung reviewed 2/4 performance measures associated with cardiovascular project. The measures include; PQI 7- Hypertension, PQI 8 Heart Failure Admission Rate, Satin Therapy for Patients with Cardiovascular Disease- Received Satin Therapy and Statin Therapy for Patients with Cardiovascular Disease- Statin Adherence 80%.	• The PMO will use quality measures to start action planning to improve clinical outcomes.

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 PPS will focus on in-network providers to ensure quality metrics are met.	• The PMO will collaborate with providers and clinical leads to implement best practices to make an impact on measurements not met.
4. Actively Engaged Patients K. Fung	**Actively Engaged Patients** • Currently the PPS has **207** actively engaged patients for DY3 Q3. • To date there is a cumulative total of **983** actively engaged patients for DY3. The PMO will need **469** more actively engaged patients to meet the target for DY3 Q4.	• The PMO encourages providers to continue referring patients to meet the actively engaged targets for DY3 Q4.
5. DY3 Q4 Deliverables: (3.31.2018) 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. **Minimum Documentation:** QE Agreements	• The PMO will continue to collect QE agreements from partners.

Topic	Discussion	Actions
	• The PMO has 4 partners connected to the RHIO, 7 partners using secured messaging and 2 partners pending RHIO agreements. • The RHIO will enhance care coordination once all partners are connected to 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 and **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	• 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 collecting policies and procedures related to blood pressure checks. • The PMO will create a workflow to indicate how the stratification system is used and implement the process in all of the NYPQ clinics.

Topic	Discussion	Actions
	Minimum Documentation: Vendor system documentation; sources demonstrating implementation of the system. • Using the National Association of Community Health Centers criteria the PMO was able to identify patients who have repeated elevated blood pressure readings by querying monthly 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 PMO will implement a semi-automated scheduling system to target patients with hypertension. • The PMO is working with internal IT resources to generate a 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 patient navigator 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. **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 is scheduled to have this metric completed before Mach of 2018. • The PMO is working with clinical leads to project a role out date. • The PMO will continue to collect policies and procedures of referral process including warm transfer protocols.

Topic	Discussion	Actions
	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 collaborate with NYPQ Health Home to document how referrals to community based organizations are facilitated. ***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 DSRIP analytics team created hot spotting data to identify high prevalent areas in queens.	• The PMO will create a workflow that documents how the PPS communicates with CBO's. • The PMO will use the real data set to identify high risk neighborhoods and train PPS partners on health homes.
6. Adjourn		-