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| **Meeting Title:** | **NYP Queens DSRIP****Cardiovascular Project**  | **Meeting Date:** | March 7, 2017 |
| **Facilitator(s):** | M. D’Urso/ M. Cartmell,  | **Meeting Time:** | 9:30 AM – 10:30 AM |
| **Conference Line:** | 866-692-4538  | **Code:** | 26098085#  |
| **Location:** | NYP/Q 56-45 Main Street; Radiation Oncology Room |

**Meeting Purpose:**

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| DSRIP Implementation – Project Requirements Implementation |

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| **#** | **Topic** | **Responsible Person** | **Document** |
| 1. | Welcome & Purpose | M. D’Urso, RN | - |
| 2. | Approve Meeting Minutes – 02/06/17 | M. D’Urso, RN |  |
| 3. | Project Deliverables DY2Q4**Milestone #5**: Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).***Metric# 5.1:*** PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.***Minimum Documentation:*** Vendor System Documentation; Other Sources demonstrating implementation of the system; Periodic self-audit reports and recommendations***Follow Up:*** Screenshots from eCW from Brightpoint and also from Athena ----------------------------------------------------------------- ***Metric 5.2:*** PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.***Minimum Documentation:*** List of training dates along with number of staff trained; Written training materials***Next Steps***: Will incorporate the training with all other trainings, probable date after March 22, 2017. Approve attached policy **(action item)** | M. D’Urso, RN/S.Choudhury |  |
| 4. | Project Deliverable DY2 Q4***Milestone #6*** Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.***Metric# 6.1:*** Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).***Minimum Documentation:*** Policies and procedures related to standardized treatment protocols for hypertension and elevated cholesterol; List of training dates along with number of staff trained; Written training materials; signed agreement with PPS organizations to implement consistent standardized treatment protocols***Next Step:*** Approve attached policy **(Action item)**  | M. D’Urso, RN/S.Choudhury |  |
| 5. | Project Deliverable DY2 Q4***Milestone #7:*** Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.***Metric# 7.1:*** Clinically Interoperable System is in place for all participating providers.***Minimum Documentation:*** Contract; Report; Vendor System Documentation; Other Sources demonstrating implementation of the system----------------------------------------------------***Metric# 7.2***: Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.***Minimum Documentation:*** Care coordination team rosters; Care coordination policies and procedures; Standard clinical protocol and treatment plans--------------------------------------------------------------------***Metric# 7.3:*** Care coordination processes are in place.***Minimum Documentation:*** 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***Follow up:*** Case Conference setup in Athena; care plan sample and case conference screenshot from Brightpoint  | M. D’Urso, RN/S.Choudhury |  |
| 6. | Project Deliverable DY2 Q4***Milestone #9:*** Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.***Metric# 9.1:*** PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.***Minimum Documentation:*** Policies and procedures; List of training dates along with number of staff trained, if applicable**Follow up:** Get roster of all staff trained or completed the annual evaluation. Any NYPQ policy  | M. D’Urso, RN/S.Choudhury |  |
| 7. | Project Deliverable DY2 Q4***Milestone #11:*** Prescribe once-daily regimens or fixed-dose combination pills when appropriate.***Metric# 11.1:*** PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.***Minimum Documentation:*** Policies and procedures ***Follow up:*** 1 page policy on medication adherence  | M. D’Urso, RN/S.Choudhury |  |
| 8. | Project Deliverable DY2 Q4***Milestone #14***: Develop and implement protocols for home blood pressure monitoring with follow up support.***Metric# 14.1:*** PPS has developed and implemented protocols for home blood pressure monitoring.***Minimum Documentation:*** Policies and procedures------------------------------------------------------------------***Metric 14.2:*** PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.***Minimum Documentation:*** Policies and procedures; Baseline home blood pressure monitoring and periodic updates exhibiting an increase of monitoring; Documentation of process and workflow including responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations------------------------------------------------------------------***Metric 14.3:*** 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:**** Approve attached best practice and policy for home blood monitoring **(Action Item)**
* Will incorporate the training with all other trainings, probable date after March 22, 2017.
 | M. D’Urso, RN/S.Choudhury |  |
| 9. | Project Deliverable DY2 Q4***Milestone #15:*** Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.***Metric 15.1:*** 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; Roster of identified patients***Follow Up:*** Screenshot of patient registry from Brightpoint. IT to get update about Athena’s capability  | M. D’Urso, RN/S.Choudhury |  |
| 10 | Project Deliverable DY2 Q4***Milestone #16*** Facilitate referrals to NYS Smoker's Quitline.***Metric 16.1:*** PPS has developed referral and follow-up process and adheres to process.***Minimum Documentation:*** Policies and procedures of referral process including warm transfer protocols***Follow up:*** Policies from Brighpoint, CHN for referral and follow up process. ***Next Steps***: Will incorporate the training with all other trainings, probable date after March 22, 2017.  | M. D’Urso, RN/S.Choudhury |  |
| 11 | Project Deliverable DY2 Q4**Milestone# 18:** Adopt Strategies from the Million Hearts Campaign***Metric# 18.1, 18.2, 18.3:*** Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign. (includes PCP, Specialists, BH)***Minimum Documentation:*** Policies and Procedures; Baseline home blood pressure monitoring and periodic updates exhibiting an increase of monitoring; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials***Next steps:*** * Approve attached best practice and policy for home blood monitoring **(Action Item)**
* Will incorporate the training with all other trainings, probable date after March 22, 2017.
 | M. D’Urso, RN/S.Choudhury |  |
| 12 | Future Deliverables: ***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 ***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:*** Risk assessment tool documentation; risk assessment screenshots, Patient stratification output; Documented protocols for patient follow-up. | M. D’Urso, RN/S.Choudhury |  |
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