**NewYork-Presbyterian/Queens PPS**

Project 3.b.i –Cardiovascular Project

*Project Committee Meeting*

*May 16th 2017 9:30am –10:30am EST*

**Attendees**: Jalen Faison (NYP/Q), Stephen Williams (Brightpoint), Coleen Dunkley (NYP/Q), Maria D’urso (NYP/Q), Robert Crupi (NYP/Q), Sadia Choudhury (NYP/Q) Marlon Hay (NYP/Q), Laquan McConnell (NYP/Q), Mayer Waxman (Selfhelp)

| **Topic** | **Discussion**  | **Actions** |
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| 1. **Agenda:**
 | * Welcome & Purpose
* Meeting minutes Approval
* Project Deliverables DY3Q4
 | * N/A
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| 1. **Meeting minutes:**

M. D’Urso | * Committee reviewed meeting minutes from 04/04/17 meeting.
 | * Committee voted to unanimously approve the meeting minutes
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| 1. **Future Deliverables**

M. D’Urso, RN/S.Choudhury | 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 ***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.***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.***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.***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.***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.***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***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***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 | * Marlon will collaborate with NYC Reach. He will use their information to see what stage of Meaningful Use each facility is on.
* Once QE agreements are collected, Healthix will get partners connected to the RHIO.
* The PPS will need to provide documentation that shows each partner is sharing data.
* Marlon/Cory will compile the screenshots for reporting out to NYSDOH
* Each facility should provide a policy and procedure or a redacted roster.
* Jalen will create a tracker to track the progress of each facility.
* Marlon will work with partners on creating a stratification system.
* Marlon and Dr. Dalal from NYPQ will create a registry in Athena for patients with repeated elevated blood pressure readings in the medical record but with no diagnosis of hypertension
* The Athena registry screenshot/sample will then be shared in the committee meeting and with other project partners so they can mimic the same in the eMR they currently have.
* Each partner will then be responsible to train the staff at their practice. PMO will collect the training sign in sheets.
* PMO will reach out to Brightpoint and CHN for their best practices and frequency for collection of the documentation self-audit of de-identified medical records demonstrating self-management goals in the clinical record
* The PMO will reach out to Brightpoint and CHN for their best practices for referrals and warm transfer protocols.
* PPS will train partners on the referral process and follow-ups.
* PMO will create a tracker and collect agreements. This will also include documentation of the workflow and the process.
* This milestone will be discussed in the Quality Integration Committee Meeting on an ongoing basis.
* QCCP, the CBO Health Home partner in the PPS network, has already trained most of the providers. Sadia or Coleen will train remaining partners on Health Home and referral process.
* More information about Stanford model will be shared in the next committee meeting
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| **4.** Care Coordination curriculum | The DSRIP/SIM Workforce Workgroup recognized the need to identify consistent care coordination training guidelines for all workers who provide care coordination services. The group worked together to identify key concepts in care coordination and shared and reviewed a wide array of care coordination training curricula. The curriculum has total of 9 modules.  | * Next step is to incorporate these modules into the PPS e-learning platform Healthstream and share with partners to get their staff trained. Sign in sheets will be collected as proof of training completion
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| **5.** Population Health curriculum  | As part of GNYHA’s continued support for member hospitals and health systems participating in the Delivery System Reform Incentive Payment (DSRIP) program, GNYHA has developed the Population Health Curriculum Guide to teach concepts and practices in this area to front-end staff, providers, and partners. The curriculum guide was developed in response to requests from GNYHA’s DSRIP Workforce Workgroup, which convenes individuals responsible for developing and implementing workforce training strategies at each of the DSRIP performing provider systems (PPSs). The curriculum guide’s content can be used by PPSs to build their population health training programs. The curriculum guide includes sections on the current health care environment, the care continuum and medical neighborhood, population health tools and capabilities, and the extended care team. Each section includes learning objectives, related content, recommended learning activities, and a case study with discussion questions. The guide also includes additional population health resources and a glossary of terms. | * Next step is to incorporate these modules into the PPS e-learning platform Healthstream and share with partners to get their staff trained. Sign in sheets will be collected as proof of training completion
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