**NewYork-Presbyterian/Queens PPS**

Project 3.b.i –Cardiovascular Project

*Project Committee Meeting*

*March 7th 2017 9:30am –10:30pm EST*

**Attendees**: P. Cartmell (NYP/Q), Donna Cheslick (NYP/Q), M. D’Urso (NYP/Q), C. Dunkley, R. Crupi (NYPW), S. Kalinowski (NYPQ) , E. Brenen (NYPQ), S. Choudhury (NYPQ), L. McConnell(NYPQ), S. Williams (NYPQ), P. Barra (NYPQ), M. Hossain (Rite Care ) M. Hay (NYPQ)

| **Topic** | **Discussion**  | **Actions** |
| --- | --- | --- |
| 1. **Agenda:**
 | * Welcome & Purpose
* Meeting minutes Approval
* Milestone 5
* Milestone 6
* Milestone 7
* Milestone 9
* Milestone 11
* Milestone 14
* Milestone 15
* Milestone 16
* Milestone 18
 | * N/A
 |
| 1. **Meeting minutes:**

A. Somogyi, M.D | * Committee reviewed meeting minutes from 02/06/17 meeting.
 | * Committee voted to unanimously approve the meeting minutes
 |
| 1. **Milestone #5**  M. D’Urso/ S. Choudhury
 | 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***Action Steps:*** Check with partners whether their EHR has capability for creating prompt. Also check with Athena for NYP clinics. collect sample documentation from each partner as evidence that they are using the 5A's of tobacco control----------------------------------------------------------------- ***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 | * Partners can send in their Athena, ECW, or EHR screen sheets.
* Please send in 5As sign in sheets to PMO
 |
| 1. **Milestone #6 :**

M. D’Urso/ S. Choudhury | 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 | * PMO will laminate protocols and sample documents to do trainings in each facility.
* Please send in training sheets to PMO.
* PMO will incorporate training around 3/22
 |
| 1. **Milestone 7:**

M. D’Urso/ S. Choudhury | 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 | * Partners can use case conferences to show proof of care coordination and send in screenshots of EHR.
* Partners send in screenshots of care coordination through EHR with care coordinator roster.
* Submit care coordination workflow per facility.

  |
| 1. **Milestone #9:**

M. D’Urso/ S. Choudhury | 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 | * Please review the Policies and procedures and vote vie email once the PMO has sent out the policies.
 |
| 1. **Milestone # 11:**

M. D’Urso/ S. Choudhury | 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  | * Please review the Policies and procedures and vote vie email once the PMO has sent out the policies..
 |
| 1. **Milestone #14 :** M. D’Urso/ S. Choudhury
 | 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 m | * Americare has shared their best practice for BP monitoring at home.
* Please review the Policies and procedures and vote vie email once the PMO has sent out the policies.
 |
| 1. **Milestone # 15:**

M. D’Urso/ S. Choudhury | 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 | Pull roster of identified patient and redact the PHI and send a screenshot to the PMO. |
| 1. **Milestone # 16 :**

M. D’Urso, RN/S.Choudhury | 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 | * Submit Policy and procedure for referrals to NYS Smoker’s Quit line and training sheets to PMO.
* Please review the Policies and procedures and vote vie email once the PMO has sent out the policies.
 |
| 1. **Milestone # 18:**

M. D’Urso, RN/ S.Choudhury | 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 | * Submit Policy and procedure for Million Hearts Campaign and training sheets to PMO.
* PMO will laminate policy and procedures for partners.
 |
| 1. **Future Deliverables:**
 | 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 | * Partners can work with Cory to be connected to the RHIO,
* Committee will discuss how to incorporate no copayment into policy and procedure.
 |
| 1. **Discussions/Questions**
 | * PMO will send out an email to vote on the policies and procedures to be standardized committee wide.
* The Webinar trainings will be held approximately March 22nd ,
 | * PMO will send out further information via email.
 |