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| **Meeting Title:** | **NYP/Q DSRIP****PCMH Project**  | **Meeting Date:** | February 6, 2017 |
| **Facilitator(s):** | M. D’Urso/ M. Cartmell,  | **Meeting Time:** | 12:00 PM – 1:00 PM |
| **Conference Line:** | 866-692-4538  | **Code:** | 26098085#  |
| **Location:** | NYP/Q 56-45 Main Street; Junior Conference 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 – 11/9/16 | M. D’Urso, RN |  |
| 3. | Project Deliverables DY2 Q4***Milestone #3:*** Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.***Metric# 3.2:*** Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities***Minimum Documentation:*** Role description of the care coordinator; Written training materials***Action steps:*** Collect care coordinator name and job description from each PCMH site. For those PCMH sites who have not sent any staff for GNYHA Care coordination training, need to provide name of their care coordinator in site***Metric 3.3:*** Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators.***Minimum Documentation:*** HIE Systems report, if applicable; Process work flows; Documentation of process and workflow including responsible resources at each stage of the workflow; Other sources demonstrating implementation of the system***Action Steps:*** Collect documents and workflows from each PCMH site; the ones who received certification should already have workflow for care coordination***Task Step 6:*** Care coordinators to provider data and feedback on PCMH as required by PMO to be incorporated for tracking and improvement mechanisms.***Action Steps:*** Collect care coordination tracker from each site and monitor on quarterly basis | M. D’Urso, RN/S.ChoudhuryM. D’Urso, RN/S.ChoudhuryM. D’Urso, RN/S.Choudhury |  |
| 4. | Project Deliverables DY2 Q4***Milestone #6*** Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.***Task Step 1#*** Utilize existing Population Health Management IT tool, Allscripts Care Director, to identify and track attributed lives by creating registries for all participating safety net providers. | M.Hay  |  |
| 5.  | Project Deliverables DY2 Q4***Milestone #8:*** Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.***Metric# 8.2:*** Protocols and processes for referral to appropriate services are in place.***Minimum Documentation:*** HIE Systems report, if applicable; Process work flows; Documentation of process and workflow including responsible resources at each stage of the workflow; Other sources demonstrating implementation of the system | M. D’Urso, RN/S.Choudhury |  |
| 6.  | Adjourn |  |  |