Meeting Title:	**NYP Queens** **DSRIP Asthma Home Based Care**	**Meeting Date:**	October 11, 2017
Facilitator(s):	H. Jabbar, MD C. Guglielmo	**Meeting Time:**	1:00 PM- 2:00 PM
Location:	NYP Queens Hospital, Junior Conference Room 1-866-692-4538 26098085#		

Meeting Purpose:

DSRIP Project Implementation – Committee meeting

#	Topic	Responsible Person	Document
1.	Welcome	H. Jabbar, MD	
2.	Review & Approve Minutes: 9.13.17	H. Jabbar, MD	Asthma Meeting Minutes 09.13.17...d
3.	***DY3 Q4 Deliverables:* (3.31.18)** **Milestone#5** Ensure coordinated care for asthma patients includes social services support. ***Metric 5.1:*** PPS has developed and conducted training of all providers, including social services and support. ***Minimum Documentation:*** Care coordination team rosters; written training materials, list of training dates along with the number of staff trained. ***Metric 5.2:*** All practices in the PPS have a clinical interoperability system in place for all participating providers. ***Minimum Documentation:*** QE Agreements ***Current Status:*** The PMO has 3 partners connected to the RHIO, 4 partners using direct mail, and 4 signed QE agreements. ***Metric 5.3:*** PPS has assembled a care coordination team that includes the use of nursing staff, pharmacist dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficiency and confidence in self-management.	H. Jabbar, MD	DY3.Q4 RHIO Tracker. Asthma.xlsx

	Minimum Documentation: Document of process and workflow including resources at each stage of the workflow. ______________________________ **Milestone #7:** Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, health home care managers, primary care providers, and specialty providers. ***Metric 7.1:*** PPS has established agreements with MCO's that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, primary care providers, and specialty providers.		
4.	**Rapid Cycle/ Quality Data:** • Quality process improvement • The clinical lead will update the committee on collaboration with ACP PPS. • The clinical lead and ACQ will educate clinical staff in the school districts on asthma initiatives. • MHPWQ and ACQ collaboration to target asthma patients in the school districts.	K. Fung/D. Natarnicola H. Jabbar, MD	Asthma MY3 Month 8 of 12 Results - Final.p Pediatric Asthma in Queens County.pdf
5.	***Actively Engaged Patients:*** • Update on actively engaged patients.	K. Fung	DY3 Q2 Actively Engaged Pts Totals (
6.	Questions & Open Discussion	Team	-
7.	Adjourn	Team	-

NewYork-Presbyterian Queens PPS

Project 3.d.ii - Pediatric Asthma Project

Project Committee Meeting

October 11th, 2017 1:00-2:00 PM ET

Attendees: L. McConnnell (NYPQ), A. Simmons (NYPQ), S. Schauman (NYPQ), M. Hay (NYPQ), C. Guglielmo (Asthma Coalition of Queens), C. Duffy (St. Mary's), C. Smith (Nicasio Arana Medical Office P.C), Nicasio Arana MD,(Nicasio Arana Medical Office P.C) N. Siddiqui (NYPQ), D. Natarnicola (NYPQ), M. D'Urso (NYPQ), J. Lavin (MHPWQ), J. Faison (NYPQ), J. Quiwa MD (Jose Quiwa P.C). , K. Fung (NYPQ) H. Jabbar, MD (NYPQ)

Topic	Discussion	Actions
Agenda:	• Welcome • Review & Approve Minutes • Deliverables • Rapid Cycle/Quality Data • Actively Engaged Patients	• N/A
2. Review Minutes:	• Review and approved minutes from **10.11.17**	• Meeting minutes were unanimously approved.
3. DY3 Q4 Deliverables (3.31.18)- H. Jabbar, MD	**Milestone#5** Ensure coordinated care for asthma patients includes social services support. ***Metric 5.1:*** PPS has developed and conducted training of all providers, including social services and support. ***Minimum Documentation:*** Care coordination team rosters; written training materials, list of training dates along with the number of staff trained. • The PMO will collaborate with CCMP to train pediatric asthma partners on care coordination and social services support. • Nancy Spiller director of Care Coordination at St. Mary's will also be a	• The PMO will draft a statement of work and once the agreements are signed the PMO will start coordinating training dates.

Topic	Discussion	Actions
	resource to the PMO to help train partners on the importance of care coordination and social service support.	
	Metric 5.2: All practices in the PPS have a clinical interoperability system in place for all participating providers. *Minimum Documentation:* QE Agreements *Current Status:* The PMO has 3 partners connected to the RHIO, 4 partners using direct mail, and 4 signed QE agreements. • New York State has mandated for all healthcare organizations to be connected to the RHIO and actively sharing data. If organizations don't have the resources to connect to the RHIO/ SHIN-NY they would have to write a letter stating their organization is facing hardship. • As of October of 2017 Healthcare organizations are allowed to share pediatric patient's data through the RHIO. Parent consent is a requirement in order to share children's health information. • St. Mary's has started sharing SNF patient's data through the RHIO. *Metric 5.3:* PPS has assembled a care coordination team that includes the use of nursing staff, pharmacist dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficiency and confidence in self-management. Minimum Documentation: Document of process and workflow including resources at each stage of the workflow. • The PMO has created hot spotting data to pinpoint high prevalence areas in queens to identify asthma patients in the school districts.	• Corey will coordinate with Healthix and they will participate in the next Asthma committee meeting. **11.8.17** • The PMO will continue to collect QE Agreements from PPS partners.

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Topic	Discussion	Actions
	• ACQ will use the Hot Spotting Data to educate clinical members in the school system on the asthma program that NYPQ DSRIP offers. • New York City Department of Education has an automated system to track student absent rates. The DOE was able to identify children being absent to asthma related symptoms. • Asthma patients from the school district are being referred to St. Mary's Home Care Program. St Mary's will connect patients to ACQ for asthma education. **Milestone #7:** Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, health home care managers, primary care providers, and specialty providers. *Metric 7.1:* PPS has established agreements with MCO's that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, primary care providers, and specialty providers. • The PMO will revisit this metric in the next asthma meeting on 10.8.17.	• ACQ will create an education pamphlet for asthma patients.
4. Rapid Cycle K.Fung, D. Natarnicola, H. Jabbar, MD	• The PMO will use the Quality data to start creating process improvement strategies to improve clinical outcomes. • The PMO can potentially earn **$196,338.52** if measurement year 3 results are all met. • The PMO can potentially lose **$104,941.04** if measurement year 3 results are not met	

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Topic	Discussion	Actions
	• Subtracting the Potential total of **$196,338.52** from metrics not met **$104,941.04** the adjusted total is **$91.397.48**	
5. Actively Engaged Patients K. Fung	• Currently the PPS has 74 actively engaged patients for DY3 Q2. • To date there is a cumulative total of 135 actively engaged patients for DY3 Q2. The PMO will need 3 more actively engaged patients to meet the target for DY3 Q2.	• The PMO encourages providers to continue referring patients for the month of October to meet the actively engaged target for DY3 Q2.
6. Questions & Open Discussion		-
7. Adjourn		-