Meeting Title:	**NYP Queens** **DSRIP Asthma Home Based Care**	**Meeting Date:**	September 13th, 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: 8/09/2017	H. Jabbar, MD	Asthma Minutes 08.09.17.docx
3.	***Rapid Cycle/Quality Data:*** • Quality process improvement • Hot Spotting data will be used to identify high prevalence areas in Queens with asthma patients. • Dr. Jabbar was able to identify the school districts with high prevalence of poorly controlled asthma patients. ***Future Deliverables :*** **All Due DY3Q4** **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	H. Jabbar, MD A. Simmons H. Jabbar, MD	Package

	Current Status: To meet this metric the PMO will collect QE Agreements and collect screen shots demonstrating clinical interoperability. ***Next Steps:*** • The PMO will assess all asthma project partners on the status of RHIO connectivity. • The PMO will collect QE Agreements and create a tracker to track the status of each partner. • The PMO will collect required screen shots. ***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.		
5.	**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. ***Minimum Documentation:*** Written Agreements ***Next Steps:*** • The PMO is currently drafting the MOU agreements. ***Actively Engaged Patients:*** • Update on actively engaged patients. The PMO collaborated with clinical leads to create the Care Pathway workflow. ***Next Steps:*** • The PMO will coordinate with asthma partners on the home assessment referral process. • The PMO will collect training materials, sign-in sheets and number of staff trained.	K. Fung	 Package

	C. Duffy from St. Mary's will confirm whether medicaid patients have a co-pay associated for a Home Care Assessment.		
6.	Questions & Open Discussion	Team	-
7.	Adjourn	-	-

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Project 3.d.ii - Pediatric Asthma Project

Project Committee Meeting

September 13th, 2017 1:00 pm-2:00 pm ET

Attendees: M. D' Urso (NYPQ), H. Jabbar, MD (NYPQ), K. Fung (NYPQ), J. Lavin (MHPWQ), C. Gugliemo (Asthma Coalition), L. McConnell (NYPQ), A. Simmons (NYPQ), N. Siddiqui (NYPQ), C. Duffy (St. Mary's), M. Hay (NYPQ), P. Cartmell (NYPQ), J. Quiwa, MD (NYPQ), E. Fardella-Roveto, NP (St. Mary's), J. Faison (NYPQ)

Topic	Discussion	Actions
Agenda:	• Welcome • Review & Approve Minutes • Rapid Cycle/Quality Data • Future Deliverables • Actively Engaged Patients	• N/A
2. Review Minutes:	• Review and approved minutes from 9/13/2017 meeting.	• Meeting Minutes were unanimously approved.
3. Rapid Cycle **H. Jabbar, MD**	**Rapid Cycle/Quality Data:** • The PMO and the clinical lead were able to identify five zip codes using hot spotting data to pinpoint high prevalence areas in Queens with asthma diagnosis. • The PMO identified school districts with poorly controlled asthma patients. • The PMO will explore collaboration with ACP PPS to make an impact on asthma patients in the identified zip codes.	• The PMO and ACQ will meet with clinical staff in the school districts to provide education on asthma initiatives. • MHPWQ and ACQ will collaborate to create a strategy to target asthma patients in the school system with poorly controlled asthma patients.

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Topic	Discussion	Actions
	• The Committee decided that the consent form and the survey are not needed to educate the clinical staff in the school districts on asthma initiatives.	
4. DY3 Q4 Deliverables (March 31st, 2017) H. Jabbar, MD A. Simmons	**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. • While conducting the home assessment evaluations St. Mary's will provide the patient with social services if additional care is needed. • Community Care Management Partners will train PPS partners on the importance of care coordination and Health Homes. ***Next Steps:*** • The PMO will collect care coordination policy along with team rosters from St. Mary's. The policy will show care coordination at each stage of care. ***Metric 5.2:*** All practices in the PPS have a clinical interoperability system in place for all participating providers. ***Minimum Documentation:*** QE Agreements ***Metric 5.3:*** PPS has assembled a care coordination team that includes the use of	• The PMO will coordinate a follow up meeting with Community Care Partners to discuss the BAA and MOU agreement in order to make referrals. • Once agreements are signed the PMO will coordinate training dates with Community Care Management partners to train the remaining pediatric partners on care coordination and Health Homes. • The PMO will continue to collect QE Agreements from PPS partners and collect screen shots to show interoperability.

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Topic	Discussion	Actions
	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. • With the assistance of the clinical lead the PMO will use the care coordination policy submitted by St. Mary's to create a work flow that identifies care coordination at each stage. **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. ***Minimum Documentation:*** Written Agreements • The PMO is currently drafting MOU Agreements to fulfill the metric requirements.	• The PMO will work with clinical leads and St. Mary's to create a workflow that identifies care coordination at each stage. • The PMO is currently drafting MOU Agreements. • The PMO will educate PPS partners on MCO's and ensure communication, and care coordination. • The PMO will educate PPS partners on the importance of Value Based Purchasing and identify the gaps in care.
4. Actively Engaged Patients	• Currently the PPS has 51 reportable actively engaged patients for DY3. Q2. • To date there is a cumulative total of 113 actively engaged patients for DY3 Q1 & Q2.	• The PMO encourages providers to continue referring patients for the month of September to

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Topic	Discussion	Actions
	• The cumulative target for DY3, Q1 & Q2 is 138 actively engaged patients therefore the committee will need 25 more patients to meet this goal.	meet the actively engaged target for DY3 Q2.
5. Question & Open Discussion		• N/A
6. Adjourn		• N/A