


	<p>Minimum Documentation: Implementation plan; evidence of use of telemedicine services</p> <ul style="list-style-type: none"> • Does any CHHA need a recommendation for telehealth services ? • We are aiming to have all our CHHAs to complete this deliverable by December 2017 in order to roll out trainings and implement by March 2018 . • Please provide a copy of contract, policy, education , patient registry of telehealth services. <p>Milestone #10: Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.</p> <p>Metric/Deliverable: Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.</p> <p>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.</p> <ul style="list-style-type: none"> • Are you connected to the RHIO ? • Marlon Hay and Laquan McConnell can assist with EHR and RHIO connectivity . 		C. Dunkley/M. Hay
4.	<p><u>Rapid Response Team</u></p> <p>Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice</p> <p>Metric 1.1 - Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for:</p> <ul style="list-style-type: none"> - discharge planning - discharge facilitation - confirmation of home care services <p>Minimum Documentation : Rapid Response Team staff; procedures and protocols, Quarterly Report narrative</p>		C. Keane

	<ul style="list-style-type: none"> We are asking our Home Cares to partner with us to assemble rapid response teams. Discharge Questionnaire /Script PMO will develop a policy for the rapid response teams that are onsite at NYP Queens. The roster will include a representative from each Home Care. 	 HHC discharge script .pdf	
6.	MOLST and eMOLST Training and Implementation <ul style="list-style-type: none"> Single Sign on update Working on rolling out trainings 		C. Keane
7.	Questions & Open Discussion	-	
8.	Adjourn	-	-

New York-Presbyterian/Queens PPS

Project 2.b.viii –HHC

Project Committee Meeting

July 24th 2017 2:00pm –2:45pm EST

Attendees: F. Emmanuel (Center light CHHA), Jennifer Lo (VNSNY), C. Duffy (St. Mary’s), C. Keane (NYPQ), F. Rosado (Americare), B. Ader (VNSNY), Therese (MJHS), S. Schuman (Parker), P, Mezei (Americare), C. Dunkley (NYPQ)

Topic	Discussion	Actions
<p>1. Agenda:</p>	<ul style="list-style-type: none"> • Welcome & Purpose • Approve Meeting Minutes • DY3 Deliverables • Rapid Response Team • MOLST & eMOLST training and Implementation 	<ul style="list-style-type: none"> • N/A
<p>2. Approve Meeting Minutes : C. Keane</p>	<ul style="list-style-type: none"> • The Committee reviewed the meeting minutes from 5/22/17 with J. Lo and F. Emmanuella approvals. 	<ul style="list-style-type: none"> • The Committee unanimously approved the meeting minutes.
<p>3. DY3 Deliverables:</p> <p>C. Keane/ C. Dunkley</p>	<p>DY3 Deliverables:</p> <p>Milestone# 8: Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.</p> <p>Metric/Deliverable: All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.</p> <p>Minimum Documentation: Care Coordination methodology, list of all participating services, medication management methodology</p> <ul style="list-style-type: none"> • The documents submitted should state: <ul style="list-style-type: none"> ○ How do you use Medication management? ○ List all services and who perform these services. ○ What is your methodology? <p>-----</p> <p>Milestone# 9: Utilize telehealth/telemedicine to enhance hospital-home care collaborations.</p> <p>Metric/Deliverable: Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise</p>	<ul style="list-style-type: none"> • PMO has created a tracker for the Partners with the due deliverables • Please send in a list of all primary care, behavioral health, and pharmacy services. • Please send PMO proof of telemedicine in the HHC • The PMO will comprise a list of

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	<p>of PCPs and staff.</p> <p>Minimum Documentation: Implementation plan; evidence of use of telemedicine services</p> <ul style="list-style-type: none"> We are aiming to complete this deliverable by December 2017 so we can ensure implementation and use by March 2018. <p>Milestone # 10: Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.</p> <p>Metric/Deliverable: Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.</p> <p>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.</p>	<p>telehealth vendors to share with the committee.</p> <ul style="list-style-type: none"> Please submit your medication reconciliation workflow, policies and procedures or education tool. PMO will reach out to CHHAs who are not connected to the RHIO. Submit your due deliverables through Performance Logic Webforms.
<p>4. Rapid Response Team: C. Keane</p>	<p>Rapid Response Team</p> <p>Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice</p> <p>Metric 1.1 - Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for:</p> <ul style="list-style-type: none"> - discharge planning - discharge facilitation - confirmation of home care services <p>Minimum Documentation : Rapid Response Team staff; procedures and protocols, Quarterly Report narrative</p> <ul style="list-style-type: none"> We are asking our Home Cares to partner with us to assemble rapid response teams. Discharge Questionnaire /Script 	<ul style="list-style-type: none"> The PMO will send out further information to the partners once the program is launched. Please use the HHC discharge script as an aid to discharge patients. PMO will develop a policy for the rapid response teams that are onsite at NYP Queens. The roster will include a representative from each Home Care

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<p>5. MOLST and eMOLST Training and Implementation: C. Keane/S. Choudhury</p>	<p>MOLST & eMOLST Trainings</p> <ul style="list-style-type: none"> • Identify Physician Champion and System Champion in each CHHA for eMOLST Training. • This may be difficult for Home Cares due to it needing a sign off by the physicians. 	<ul style="list-style-type: none"> • Please submit physician champion and system champion at each CHHA. • PMO will update committee when trainings will be starting.