





Meeting Title:	NYP/Q DSRIP Hospital-Home Care Project Sub-Committee	Meeting Date:	September 25th , 2017
Facilitator(s):	Caroline Keane	Meeting Time:	2:00 PM – 2:45 PM
Dial in #:	NYPQ Radiation Oncology Room Call in #1-866-692-4538		Passcode: 26098085#

Meeting Purpose:

1. DSRIP Project Implementation – Milestones & Tasks

#	Topic	Document	Responsible Person
1.	Welcome & Purpose	-	C. Keane
2.	Approve Meeting Minutes – 07/24/17	 NYPQ PPS HHC Meeting Minutes 7.24	C. Keane
3.	<p>DY3 Tasks Tracker:</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"> • How do you do Medication Management ? • Is there education on Medication Management ? <p>-----</p> <p>Milestone# 9: Utilize telehealth/telemedicine to enhance hospital-home care collaborations.</p> <ul style="list-style-type: none"> • Telemedicine Reimbursements issues • Status of Telemedicine <p>Metric/Deliverable: Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.</p>	 HHC Task Tracker_DY3.xlsx  HHC DY3 Project Plan.pdf	C. Keane/ C. Dunkley

	<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 ? Laquan McConnell can assist with EHR and RHIO connectivity. 		C. McConnell
4.	<p>MOLST and eMOLST Training and Implementation</p> <ul style="list-style-type: none"> Working on rolling out trainings in the upcoming months 		C. Keane
5.	<p>Root Cause Analysis</p> <ul style="list-style-type: none"> PPS will have monthly RCA meetings with onsite home cares. We will send out the patient information a week ahead of the RCA date to prepare for the RCA and conclude with action plans. For the home cares off site we will expect each facility to complete their own RCA and complete the templates given by the PMO with action plans. 		C. Keane/ C. Dunkley
6.	<p>Performance Measures</p>	 LTC Measures.pdf	K. Fung D. Notarnicola

7.	Adjourn	-	-
----	---------	---	---

Topic	Discussion	Actions
	<p>Metric/Deliverable: Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise 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>in the HHC</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. MOLST and eMOLST Training and Implementation: C. Keane/S. Choudhury</p>	<p>MOLST & eMOLST Trainings</p> <p>The PMO will send out palliative education modules to the homecare for physicians, medical assistants, and social workers.</p>	<ul style="list-style-type: none"> The PMO will update the committee with information once released.
<p>5. Root Cause Analysis C. Keane</p>	<ul style="list-style-type: none"> PPS will have a RCA meeting with VNS on 10/16/2017 on site at NYPQ. The hospital will send out a patient roster monthly and do a RCA on 4 chosen patients. For homecare offsite we will give you the templates to complete at your facility. 	<ul style="list-style-type: none">
<p>6. Performance Measures K. Fung</p>	<ul style="list-style-type: none"> K. Fung presented MY2 data to the committee with all performance measures met from providers in and out the PPS network. 	<ul style="list-style-type: none"> The PMO will work with clinical leads to develop process improvement action plans for providers.