





Meeting Title:	NYP/Q DSRIP Hospital-Home Care Project Sub-Committee	Meeting Date:	February 12 th 2018
Facilitator(s):	Caroline Keane	Meeting Time:	2:00 PM – 2:45 PM
Dial in #:	MRI Conference Room Call in #1-866-692-4538		Passcode: 26098085#

Meeting Purpose:

1. DSRIP Project Implementation – Milestones & Tasks
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#	Topic	Document	Responsible Person
1.	Welcome & Purpose	-	C. Keane
2.	Approve Meeting Minutes – 11/20/17	 NYPQ PPs Home Care Minutes 11.20.	C. Keane
3.	MY3 Performance measures- Month 11 of 12	 LTC - MY3 Month 11 of 12 Performance R	K. Fung
4.	<p>DY3 Tasks Tracker:</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> <hr/> <p>Milestone# 9: Utilize telehealth/telemedicine to enhance hospital-home care collaborations.</p> <ul style="list-style-type: none"> • Eligibility status & policy and procedure 	 Rapid Response Team.pdf - Adobe A  HHC Task Tracker_DY3v1.xlsx	C. Keane/ C. Dunkley

	<ul style="list-style-type: none"> • Status of Telemedicine • VNSNY Telemedicine follow up <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 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>C. McConnell</p>
5.	<p>Root Cause Analysis</p> <ul style="list-style-type: none"> • The PPS will have monthly RCA meetings with onsite home cares. We will send out the patient’s case information a week ahead of the RCA date to prepare for the RCA and develop 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. <ul style="list-style-type: none"> ○ The Home care will then submit their template as proof 		<p>C. Keane/ C. Dunkley</p>
6.	Adjourn	-	-

New York-Presbyterian Queens PPS

Project 2.b.viii –HHC

Project Committee Meeting

February 13th 2018 2:00 PM- 2:45 PM ET

Attendees: K. Fung (NYPQ), Jennifer Lo (VNSNY), C. Duffy (St. Mary's), S. Schuman (NYPQ), M. Kennedy (VNSY), C. Keane (NYPQ), D. Forbes (Alpine), K. Dier (MJHS)

Topic	Discussion	Actions
1. Agenda:	<ul style="list-style-type: none">• Welcome & Purpose• Approve Meeting Minutes• DY3 Task Tracker• Root Cause Analysis• Performance Measures• Adjourn	<ul style="list-style-type: none">• N/A
2. Approve Meeting Minutes: C. Keane	<ul style="list-style-type: none">• The committee reviewed the meeting minutes from 11.20.17.	<ul style="list-style-type: none">• The committee unanimously approved the meeting minutes.
3. Performance Measures: K. Fung	<ul style="list-style-type: none">• K. Fung reviewed six quality measures that are associated with the long-term care projects. The six quality measures that were discussed are preventable ED visits, PQI 90, potential avoidable readmissions, Adult Access preventive (20-44),(45-64) and (65 and older).• Out of the six quality measures presented, potentially preventable ED visits were the only quality metric met.• The PPS did not meet the quality metrics for PQ90 and potentially avoidable readmissions, adult access, and potentially avoidable readmissions.	<ul style="list-style-type: none">• The PMO will use quality data to start action planning to improve clinical outcomes.

Topic	Discussion	Actions
<p>4. Root Cause Analysis C. Keane</p>	<p>Root Cause Analysis:</p> <ul style="list-style-type: none"> • The PPS will continue to have monthly RCA meetings with onsite Home Care partners. <ul style="list-style-type: none"> ○ C. Keane will share a list of action plans in the next Home Care committee meeting. ○ C. Keane is requesting each onsite Home Care partner to have a designated person to represent quality in the next committee meeting. • For offsite Home Care partners, the Pennsylvania Root Cause analysis tool should be completed and submitted to the PMO. 	<ul style="list-style-type: none"> • Please complete the Root Cause analysis forms and submit it to the PMO.