




Meeting Title:	NYP/Q DSRIP Hospital-Home Care Project Sub-Committee	Meeting Date:	November 20 th , 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
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#	Topic	Document	Responsible Person
1.	Welcome & Purpose	-	C. Keane
2.	Approve Meeting Minutes – 10/23/17	 NYPQ PPS Home Care Minutes 10.23.1	C. Keane
3.	<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> <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,</p>	 HHC Task Tracker_DY3.xlsx  HHC DY3 Project Plan.pdf	C. Keane/ C. Dunkley

5.	Performance measures	 LTC - MY3 Month 9 of 12 Performance Re	K. Fung
6.	Adjourn	-	-

New York-Presbyterian Queens PPS

Project 2.b.viii –HHC

Project Committee Meeting

November 20th, 2017 2:00 PM- 2:45 PM ET

Attendees: K. Fung (NYPQ), J. Faison (NYPQ), Jennifer Lo (VNSNY), F. Emmanuel (Center Light CHHA), C. Duffy (St. Mary’s), S. Schuman (NYPQ), F. Rosado (Americare), I. McConnell (NYPQ), I. Parker (Parker Jewish), M. Kennedy (VNSY), M. D’urso (NYPQ) C. Keane (NYPQ)

Topic	Discussion	Actions
<p>1. Agenda:</p>	<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
<p>2. Approve Meeting Minutes: C. Keane</p>	<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.
<p>3. DY3 Deliverables: C. Keane</p>	<p>DY3 Task 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>	<ul style="list-style-type: none"> • PPS partners please submit rapid response team roster and policy and procedure by December 2017.

Topic	Discussion	Actions
	<p>documents are collected, the PMO will work with partners to ensure implementation and use by March 2018.</p> <ul style="list-style-type: none"> • VNS updated the committee on their telehealth program progress. The two groups of patients they conducted their study on were telehealth and non-telehealth patients. <ul style="list-style-type: none"> ○ VNS was able to identify patients that used the telehealth services were between the ages of 90-95 years old. Over 75 % of the patients that used the telehealth services were re-hospitalized after 30 days. All telehealth patients were on oxygen and had sepsis. ○ VNS also looked at patients who were non-telehealth patients and they were all 70 years old and younger. Over 60% of the non-telehealth patients were re-hospitalized after 30days. All non-telehealth patients weren't on oxygen and it was their first time being hospitalized. ○ VNS used a home grown tool to screen patients for telehealth the piolet. ○ VNS will share the policy with the committee in the next Home Care meeting. <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>questions/concerns for implementation.</p> <ul style="list-style-type: none"> • If you need help connecting to the RHIO please contact Corey McConnell .

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.
<p>5. Performance Measures: K. Fung</p>	<ul style="list-style-type: none"> • K. Fung reviewed 3 quality measures that are associated with the long term care projects. The three quality measures that were discussed are preventable ED visits, PQ90, and potential avoidable readmissions. • Out of the three quality measures presented, preventable ED visits were the only quality metric met. • The PPS did not meet the quality metrics for PQ90 and potentially avoidable readmissions. 	<ul style="list-style-type: none"> • The PMO will use quality data to start action planning to improve clinical outcomes.