Discharge Planning Workgroup Meeting
Minutes for Meeting of March 26th, 2009
40 North Pearl Street, (16 floor CR) Albany, 217 So Salina Street, (Room 4A)
Syracuse Area Office, 317 Lenox Avenue, (Room 909) New York City Office
10:00 am – 12:00 –pm

NEXT MEETING: **June 25th, 2009, 10 a.m. – 12:00 p.m.**

Present:

Diana Abadie	DOH
Stacey Agnello	NYS Office for Aging
Linda Camoin	OTDA
Peter Brown	Inst. of Behav. Hlth. & Mgmt
Eleanor Canning	VNSNY
Lisa Clark	OMH
Anna Colello	DOH
Lynn Cortella	NYSDOCS
Mary Ann Cresanti	NYS Nurse Practitioner's Assoc
Lou Czynski	Bronx-Lebanon Highbridge-Woodycrest Ctr
Diane Darbyshire	NYAHSA
Robert DeAngelis	Kings Arms Assisted Living
Beth Eisenhandler	DOH
Phyllis Erlbaum	Jewish Home Life Care
Leah Farrell	Center For Disability Rights
Fran Gautier	NYC Chapter of N.S.W. Association
Deborah Greenfield	Bureau of Adult Services – OCFS
Anne Hill	NY Assoc. for Homes & Services for Aged
Karen Jackuback	Develop. Disabilities Planning Council
Allison Kochman	GNYHCFA
Roz Larrabee	Ingersoll Place Assisted Living
Mary McLaughlin	Albany Medical Center
Kathleen Minucci	DOH
Catherine Morris	Stony Brook Univ Med Ctr
Marsha Noren	Smithtown Center
Martha Patterson	Visiting Nurses Assoc. of Albany
Kathy Paul	VNS of Schenectady & Saratoga Counties
Paula Reichel	Community Health Center
Michael Schaeffer	Albany Medical Center
Brenda Scovello	Kings Arms Assisted Living
Terese Seastrum	NE Health
Christine Stegel	IPRO
Gerald Stenson	DOH
Sharron Tedesco	VNA of Schenectady & Saratoga Counties
Roxanne Tena-Nelson	CCLC
Patty Willsey	Albany Co. Dept of Social Services

Present by phone: (Marty McMahon, Suzanne Barg, Kathy Spano)

Welcome Members, Anna Colello	Anna welcomed all conference participants from each of the three video conferencing locations
Sue Barg and Marty McMahon (CDRO) **Champlain Valley Complaint**	DOH responded to a call regarding a hospital discharge. The matter was investigated by both the hospital and adult home programs. The investigation revealed that there had been communication issues between the hospital and the county and the individual had to be returned to the hospital. The County and Hospital met to discuss the communication breakdown and developed a process to ensure effective communication in the future.
Christine Stegel IPRO **Small Workgroup**	Summary of Case 0001: **Patient's presenting symptoms**: Patient was brought to the ER by her sister who reported she was hit by a taxi. Patient was admitted to hospital for a non-acute condition by Albany County Dept. Social Services (DSS)-adult protective services (APS) because sister refused to take the patient home. Patient was homeless. Patient has been in the hospital for 265 days. **Psycho/social history**: Prior to hospitalization, patient had been cared for and lived with her mother who had passed away leaving her with no primary caregiver. The patient had a sister who was unwilling to assume responsibility for her care. Patient had a history of mental illness and had limited intelligence. The patient was deemed unsafe to live independently. Patient was Medicaid eligible. **Barriers to discharge**: Patient did not qualify for services through NYS OMRDD or NYS Office of Mental Health because there was no definitive diagnosis of mental retardation, developmental disability, or mental health diagnosis. Patient was not safe to live independently; sister was not willing to be responsible for her sister. Patient had low intelligence. **Discharge Planning Strategy:** 1. Albany County APS working was contacted and opened the patient to services

	2. There was an investigation into whether patient qualified for Office of Mental Retardation and Developmental Disability or Office of Mental Health and was found not to qualify due to any definitive diagnosis of mental retardation or mental illness. Patient did have a neuro/behavioral evaluation. 3. Patient was deemed competent to make discharge planning decisions, although a temporary guardian was appointed. 4. Supervised housing setting was investigated. Patient was appropriate for assisted living facility or another supervised group home setting. There was not an organization that felt she was appropriate for their facility. 5. Patient was discharged to a neuro/behavioral facility in Massachusetts.
Diana Abadie **Office of Long Term Care (DOH)** **Universal Transfer Data**	The OLTC is exploring regulatory transfer language rather than mandating a form. There will be a formal process for comments at such time that the regulations are posted.
Linda Camoin **Dates for Future Meetings** **Future Topics**	The group decided that Fridays are not good, so she will look to book the room on Thursdays going forward. The next meeting is June 25, 2009 from 10:00 a.m. – 12:00 p.m.