Discharge Planning Workgroup Meeting
Minutes for Meeting of June 25th, 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: September 24, 2009, 10 a.m. – 12:00 p.m.

Present:
Amor Bango VNACNY
Michelle Berry CASA-Broome County
Cherry Bowhall St. Joseph’s Homecare
Mary Caram Harlem Hospital Center
Eleanor Canning VNSNY
Lisa Clark OMH
Anna Colello DOH
Lynn Cortella NYSDOCS
Lou Czynski Bronx-Lebanon Highbridge-Woodycrest Ctr
Kelly Donohue GNYHA
Phyllis Erlbaum Jewish Home Life Care
Leah Farrell Center For Disability Rights
Margaret Gorman NYSHCP
Deborah Greenfield Bureau of Adult Services – OCFS
Marge Jordan DOH-Home Care/WRO
Maire Kavanagh Consultant
Darius Kirstein NYAHSA
Allison Kochman GNYHCFA
Andrew Koski Home Care Assoc.of NYS
Roz Larrabee Ingersoll Place Assisted Living
Patricia Madia DOH-ACF Program/Div of Res Services
Kathleen Minucci DOH-SNF Program/Div of Res Services
Kelly Mussi VNA of CNY
Paula Reichel Community Health Center
Cindy Riecker Home Instead
Denise Rosemond Bronx-Lebanon Highbridge Woodycrest Ctr
Kathy Salvaterra VNA of CNY
Michael Schaeffer Albany Medical Center
Terese Seastrum NE Health
Lynn Shannon DOH-Home Care/Syracuse
Indi Shelby VNA of CNY
Gerald Stenson DOH-Certification and Surveillance
Roxanne Tena-Nelson CCLC
Patty Willsey Albany Co. Dept of Social Services
Danny Yuricic IPRO
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<th>Welcome Members, Anna Colello</th>
<th>Anna welcomed all conference participants from each of the three video conferencing locations</th>
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<td><strong>Paula Reichel - Community Health Center</strong></td>
<td>Community Health Center is a certified Home Care and Long Term Care Agency in rural Fulton and Montgomery Counties. This case of a 68 year old, divorced, female who is “marginally functional” was admitted to our agency from the hospital 5/1/09. This patient had many co-morbidities and no physician to follow up with her. She was admitted to our community mental health nurse service and they convinced a psychiatrist to follow her. This patient had very acute bronchitis, a tobacco use disease and a long history of schizophrenia. There was a long history of non compliance with meds and treatments and was constantly using cleaning agents in her home. Adult Protective Services worked us on this case, as well as the Fulton County Mental Health Clinic. Because of the excellent coordination between the hospital discharge planner, and CHC staff and APS this patient is maintained at home and doing well.</td>
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<td>Perspectives from Home Care</td>
<td>Ms. Bango discussed the two scenarios (to be attached in DPW meeting notice) along with the transition of care letter (to be attached in DPW meeting notice) that they are sending to hospital on patients needing more coordination prior to admission to home care.</td>
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<td><strong>Amor Bango-VNA of CNY</strong></td>
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<td><strong>Indi Shelby-VNA of CNY</strong></td>
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<td><strong>Christine Stegel IPRO Complex Discharge Planning Subcommittee</strong></td>
<td>The complex discharge planning subcommittee has met three time to discuss patients that have had complex discharge planning needs that required a higher level of interdisciplinary and community service care coordination. The purpose of the subcommittee is to provide a venue where health care organizations can bring their scenarios about patient who have complex needs and who are causing discharge planning/care coordination difficulties. The intent is to develop recommended strategies or interventions that can be used as a guide for other organizations who have similar patient scenarios. It is</td>
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expected that these recommended strategies will be posted on the NYS Department of Health website in the Discharge Planning section. A case study document has been created and must be completed prior to the patient being discussed at the meeting. Subcommittee members include representatives from NYS agencies, community service agencies, and health care providers. The subcommittee meets monthly on the first Wednesday of the month. The case study document will be posted to the NYS Department of Health website in the Discharge Planning section. The July subcommittee meeting is being cancelled to allow for the case study document to be distributed and publicized. The facilitator for the subcommittee is Christine Stegel from IPRO. Her contact information is cstegel@nyqio.sdps.org or telephone number is 518-426-3300 ext 113.

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<th>Danny Yuricic</th>
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<td>Nursing Homes/Hospitals Cross Settings</td>
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Mr. Yuricic focused on effective communication in pressure ulcer care between hospital and nursing home. Specifically, it looked at how lack of communication between staff may affect pressure ulcer care. Effective communication between staff/settings usually will enhance the quality of care provided to that specific resident/patient especially in the prevention and/or treatment of pressure ulcers.

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<th>Wrap Up</th>
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<td>Stacey Agnello - NYS Office for Aging</td>
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RTZ Associates, Inc. was awarded the contract to develop the Statewide Long Term Care Resource Directory. Once up and running, the directory will be accessed through our current nyconnects.org URL.

We are working with RTZ to develop a migration plan and schedule to migrate local resources at the county level into the statewide system.

The next meeting is September 24 2009 from 10:00 a.m. – 12:00 p.m.