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

Welcome Members, Anna Colello	Anna welcomed all conference participants from each of the three video conferencing locations
Paula Reichel - Community Health Center **Perspectives from Home Care** **Amor Bango-VNA of CNY** **Indi Shelby-VNA of CNY**	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. Ms. Bango discussed the two scenerios (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.
Christine Stegel IPRO **Complex Discharge Planning Subcommittee**	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

	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.
Danny Yuricic IPRO **Nursing Homes/Hospitals Cross Settings**	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.
Wrap Up **Stacey Agnello - NYS Office for Aging** **Dates for Future Meetings**	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.