

| NY/IPRO Using Data to Drive Improvement in Albany Community Work Plan | | | | | | | | |
|--|---|------------|--------------------|---------|---|--|--|--|
| Albany HRR Community Work Plan January 2013 | | | | | | | | |
| Key Tasks | | | Key Milestones | | | | | |
| Task Description | Activity/Approach | Start Date | Completion Date | Status | Expected Outcome | | | |
| Community will convene a meeting that includes community service, health care providers, consumers and other stakeholders to discuss long term care planning for medically complex patients | Each County Office for Aging or rural health agency will schedule a presentation by IPRO Project Team to provide a Special Innovation Project overview to their members to discuss and offer feedback. The meetings will contain a cross-setting representation of providers, consumers and other stakeholders from within their community. | 10/17/12 | 2/28/13 | Ongoing | Meeting Attendance and Meeting Summaries Engaged and activated community | | | |
| Albany HRR acute care and critical access hospital Directors of Case- management/Discharge Planning will meet with IPRO to discuss successes and challenges for coordinating post- acute care for medically complex patients | Interview of Albany HRR acute care and critical access hospital Directors of Case- management/Discharge planning to discuss their specific issues related to long term planning for post acute care for medically complex patients | 10/17/12 | 2/28/2013 | Ongoing | Meeting Summaries Best Practice & Challenges Summary | | | |



| NY/IPRO Using Data to Drive Improvement in Albany Community Work Plan | | | | | | | |
|--|---|------------|--------------------|----------------------|--|--|--|
| Albany HRR Community Work Plan January 2013 | | | | | | | |
| Key Tasks | | | Key Milestones | | | | |
| Task Description | Activity/Approach | Start Date | Completion Date | Status | Expected Outcome | | |
| Community post acute providers will offer their input related to long term care planning for medically complex cases. | IPRO team will contact providers of post acute services: SNFs, Critical Access Hospitals (swing beds utilization), hospitals with transitional care units, LTCHs, acute rehabilitation facilities for interview | 10/17/2012 | 2/28/2013 | Ongoing | Meeting Summaries | | |
| The community will create a definition of a clinically complex patient. | IPRO will assist the community to define the characteristics of this patient population in an effort to better manage their post-acute hospital period. | 1/1/13 | 6/30/13 | In Process | Common definition of clinically complex patient and preferred care management plan | | |
| The community will convene a Learning and Action event to share the results of the community meetings and individual interviews. | Schedule a Summit conference with invitations to community leaders, health officials, consumers, and other stakeholders. | 4/16/13 | 4/16/13 | In planning phase | Event registration, attendance and evaluation summaries | | |
| The community will identify best practices that are exhibited by a provider agency or group of providers. The best practices will be showcased during the Community LAN event on 04/16/13 | During the community root cause analysis the project team will identify a Best Practice that has been implemented in an effort to streamline patient's transition at hospital discharge. | 2/28/13 | 4/16/13 | in planning phase | Development and sharing of a compendium of best practices | | |



| NY/IPRO Using Data to Drive Improvement in Albany Community Work Plan | | | | | | | | |
|--|--|------------|--------------------|------------------------|--|--|--|--|
| Albany HRR Community Work Plan January 2013 | | | | | | | | |
| Key Tasks | | | Key Milestones | | | | | |
| Task Description | Activity/Approach | Start Date | Completion Date | Status | Expected Outcome | | | |
| The community will agree upon community metrics to track during project time period | Examine patient related Medicare claims data to identify trends and care patterns for patients who are clinically complex patients; present potential community metrics at LAN event. | 10/1/12 | 9/1/2013 | Ongoing | Create a dashboard report to present at LAN event. | | | |
| The community will Identify a cross- setting QI initiative to enhance transition of clinically complex patients within their community. | At the Learning and Action event, facilitate participants in development of a QI initiative that will assist in streamlining the transition of clinically complex patients post hospital discharge. | 4/16/13 | 5/30/13 | In planning process | Survey results | | | |
| The community members will establish a regular meeting schedule for QI initiative development and measurement. | Establish meeting times within the community for QI activity development and measurement. | 5/1/13 | 9/27/2013 | In planning process | Develop QI initiative and perform PDSA cycles. | | | |