Meet ACO’s Needs:

Utilize Patient-Centric Standardized Care Processes and Sustain Exceptional Outcomes with Clinical Pathways

National Association for Home Care & Hospice October 2013

Presented by:
Lisa Van Dyck, RN MSN Eventium, LLC, VP, formerly VNA First / IHCS
Cindy Nyquist, RN MSN President, CEO Upper Peninsula Home Health, Hospice & Private Duty

Introductions

Cindy Nyquist, RN MSN President, CEO
Upper Peninsula Home Health, Hospice, Private Duty
- Agency Description

Lisa Van Dyck RN MSN, Eventium
Formerly VNA First / Innovative Healthcare Solutions
Meet ACO Needs with Pathways

NAHC October 2013

Agenda

Healthcare Reform - ACOs

Key Concepts

Home Care's Role

"Must have" Qualities & Tools

Clinical Pathway's Role

Step by Step Patient Education Tools

VNA First Home Care Steps® Pathways

Case Study

Data Pre - Post Clinical Pathways

Pathways & Results, Marketing

Q/A

HHS National Strategy for Quality Improvement in Health Care

TRIPLE AIM

Better Care – pt centered, safe

Healthy Communities – proven interventions to address behavioral, social, environmental determinants of health

Affordable Care – individuals, families, employers, government

#1 Target

Healthy Communities

Patient Centered Care

Better Outcomes

ER & ACH

Healthcare Reform and Care Transitions
Defining Care Transitions: Hand-Off

“The transitional period between sites of care is an especially vulnerable time for patients, often characterized by conflicting medical advice, medication errors, and a lack of additional treatments that might have been avoided. Care transitions interventions are designed to target these problems and ease the transition between sites.”

Dr. Eric Coleman, MD

Four Pillars of Care Transitions

Dr. Eric Coleman  http://www.caretransitions.org/
Transition Coaches

- The ability to shift from doing things for a given patient to encouraging them to do as much as possible for themselves
- Competence in medication review and reconciliation
- Experience in activating patients to communicate their needs to a variety of health care professionals.

Follow patient for 30 days

F/up in homes

Telehealth

Teach Back = Focus on Outcomes!

- Explain
- Assess
- Clarify
- Understanding

- Verbalizes three (3) S/S of exacerbation and appropriate measures to take.
- Verbalizes importance of taking pulse and reporting pulse less than 60 and over 120.
- Verbalizes importance of monitoring daily weight.
ACOs – Accountable Care Organizations

FFS continues

Shared Savings

- eventually shared loss

5,000 FFS beneficiaries

Evidence-based medicine, report on quality and cost measures and coordinate care

Meet patient-centeredness criteria

ACO Performance Indicators (33)

ACO 8 – 10: Risk 30 day Readmission (COPD, Asthma, CHF)
ACO 12: Med reconciliation
ACO 13: Falls, Screening
ACO 14: Influenza immunization
ACO 15: Pneumococcal vaccination
ACO 16: BMI, follow-up
ACO 17: Tobacco use, cessation
ACO 18: Depression screening, f/u
ACO 19-20: Colon and Breast screening
ACO 21: BP screening, fu
ACO 22-25: Diabetes: HgbA1c, LDL-C and BP control, Tobacco non-use
Hospital Readmission Reduction Program

2013
- 1% cut max
- AMI, HF, Pneumonia
- $280 Million Estimated Savings/year
- 0.3% Hospital Payments

2014
- 2% cut max
- Same conditions

2015
- 3% cut cap
- Adding COPD, CABG, PTCA & Other Vascular, Hip and Knee surgery
- 2012 – added Central line infection, Safety composite measure and Medicare spending/beneficiary efficiency measure

DRG ↓ based on hospital ratio of expected to actual readmissions


ACO Core Competencies
Deloitte’s Perspective

- Care Management:
  - Ability to manage clinical pathway adherence by care teams
  - Ability to design and align population-based health management processes with evidence-based guidelines
  - Ability to coordinate care across patient conditions, services, and settings over time
  - Ability to manage patient behavior and implement patient outreach, adherence and self-care

Source:
What About **Home Care**?

- Proposed and Final Rules – don’t include “home care” in the language
- Hospitals and Physicians likely to be in control
- Homecare agencies are getting nervous
- Need to *Partner* NOW to help manage and control post-acute / community care

How? Alignment – Strong Relationships

HOME CARE

- Physicians
- Hospitals
- ACOs
Get in the Door...Talk the Talk

<table>
<thead>
<tr>
<th>EHR</th>
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<tbody>
<tr>
<td>How you can HELP THEM improve their outcomes and prevent loss, save $$$$$!</td>
</tr>
<tr>
<td>30 Day Readmission Penalties</td>
</tr>
<tr>
<td>Offer to take their frequent flyers</td>
</tr>
<tr>
<td>Care Transition Tools</td>
</tr>
<tr>
<td>Standardized Care – clinical pathways</td>
</tr>
<tr>
<td>Chronic Disease Management Programs</td>
</tr>
<tr>
<td>Home Care Reduces READMISSIONS SHOW THE DATA!</td>
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**Study:** Medicare Savings and Reductions in Rehosp’s Associated with **Home Health Use**

**20,426 fewer hospital readmissions**
(CHF, COPD, Diabetes)
VS. SNF, Other post-acute

**$2.81 billion reduction** Medicare Part A
(2006-2009)

Estimated **$2.07 billion additional reduction** if received Home Care vs Other Post Acute service

Source: Study by: Avalere Healthcare, LLC, Reported in Remington Report (Sept/Oct 2011)
Meet ACO Needs with Pathways

Study Cont: % Discharge to Post Acute Care

<table>
<thead>
<tr>
<th>10%</th>
<th>● Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>● LTC</td>
</tr>
</tbody>
</table>

Lower satisfactions scores
- On “discharge” questions (CAHPS)
- NO CARE! yet many with multiple chronic diseases, wound, not homebound?

Source: AHRQ, Reported in Remington Report (Sept/Oct 2011)

Premier Post-Acute Partner

EHR / EMR
Home Care, Hospice, Private Duty, Transitional Care
Medicare/State Surveys; No issues with ADRs, Pay Packs

HHQI – Outcomes – top 20%
- **Hospitalization indicator
- Better than the national and state rates

HHQI – Process – top 20%

HHCAPHS Satisfaction measures – top 30%
Low Risk Partner - Sustainability

MUST be able to DEMONSTRATE ABILITY TO SUSTAIN OUTCOMES with:

<table>
<thead>
<tr>
<th>STANDARDIZED CARE PROCESSES</th>
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<tr>
<td>PROACTIVE CARE</td>
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<tr>
<td>PREDICTIVE CARE</td>
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<table>
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<tr>
<th>EVIDENCE – BASED, BEST PRACTICE</th>
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<tr>
<td>INTEGRATED</td>
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<tr>
<td>VISIT NOTE</td>
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<tr>
<th>OUTCOME - DRIVEN</th>
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<tbody>
<tr>
<td>PATIENT CENTERED</td>
</tr>
<tr>
<td>UNIQUE CARE</td>
</tr>
</tbody>
</table>

EBP & Best Practices

- Transitional Care, Teach Back, Transition Coaches
- Condition Specific EBP - ADA, AHA, etc
- HHQI – OASIS Outcome & Process Indicators
- CAHPS – Satisfaction - 30% process related
- Chronic Disease Management Programs
- ACO, Payer & Accreditation Requirements
HOW to Demonstrate Low Risk?

**Clinical Pathways!**

Clinical Pathways – outcome-driven, step by step model:
- VNA FIRST *Home Care Steps*® Pathways & CoSteps

Patient Education Tools – outcome-driven, Step by Step model:
- Step by Step Patient Education Guides

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**Care Plans VS Pathways**

<table>
<thead>
<tr>
<th>Care Plan</th>
<th>Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>- List of Interventions &amp; Outcomes BY EPISODE</td>
<td>- List of Interventions &amp; Outcomes BY VISIT / ENCOUNTER</td>
</tr>
</tbody>
</table>
### CHF Care Plan *(Interventions – episode)*

**PLAN for VISIT: Routine Visit, continue CHF Care Plan per care manager**

- Evaluate knowledge of S/S to report to RN/Physician and those that need immediate medical attention. (Refer to Zone/Red Flag Plan. Use Teach Back Method to determine comprehension. Ask patient to repeat in Their OWN WORDS.
- Instruct on definition of disease process and basic treatment goals.
  - Instruct on importance of good skin care to edematous areas; s/s of skin breakdown and what to report.
- Instruct on causes of pedal edema and measures to control or reduce edema.
  - Evaluate ability to assess pedal edema and to appropriately notify physician/RN.
- Instruct to record weight daily and to report weight gain of > 2 lbs. in 24 hours, > 3 lbs. in 48 hours, > 5 lbs. in 7 days or as per physician order.
- Evaluate ability to take pulse, demonstrate as needed.

*Each clinician pick and choose from the list to assess, teach, etc*

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**PLAN FOR NEXT VISIT? “As per care plan”, “As per case manager”**
Step by Step Example – CHF Pathway

Nut/Hyd/Elim

- Instruct on diet/ fluid restrictions
- Verbalizes general dietary restrictions

√ Safety

Step 2

- Instruct on how to calculate sodium content of food/fluids
- Verbalizes how to calculate sodium content of food/fluids
- Demonstrates compliance with diet/fluid restrictions

√ Disease Control

Step 5

- Instruct on selection of appropriate restaurant foods
- Verbalizes knowledge of appropriate restaurant foods

√ Health Promotion

Step 8

- Instruct on selection of appropriate restaurant foods
- Verbalizes knowledge of appropriate restaurant foods

√ Health Promotion

CHF Pathway Step 2 Interventions

**PLAN for VISIT: Advance to: CHF Step 2**

<table>
<thead>
<tr>
<th>Disease Process</th>
<th>Interventions</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V</td>
<td>Assess/verify patient identity with name and date of birth, if new to home care associate.</td>
<td>1. Demonstrates no new, worsening continued S/S outside normal range at anytime during the visit</td>
</tr>
<tr>
<td>V</td>
<td>Assess circulatory/cardiac status; VS; heart rate/rhythm; orthostatic BP; weight, edema; note change in status.</td>
<td>B. Or since last visit.</td>
</tr>
<tr>
<td>V</td>
<td>Assess level of dyspnea with activity and at rest, not continued S/S outside normal range at anytime during the visit.</td>
<td>2. Demonstrates ability to maintain medical condition in home without ER, hospital or unplanned physician visit.</td>
</tr>
<tr>
<td>V</td>
<td>Hospital or unplanned physician office visit.</td>
<td>Provide contact phone numbers and who to contact during evenings and weekends for symptoms/concerns.</td>
</tr>
<tr>
<td>V</td>
<td>Instruct on use of oxygen for disease process.</td>
<td>Diabetes with Insulin</td>
</tr>
</tbody>
</table>

**Step 2 – ALL interventions are expected to be completed. If they are not, then need to indicate reason why with a Variance code**
**CHF Pathway Step 2 Outcomes**

**Step 2 – All Outcomes are expected to be achieved. If they are not, then need to indicate reason why with a Variance code**

- A. Demonstrates no new, worsening continued S/S outside normal range at anytime during the visit
- B. Or since last visit.
- C. Demonstrates ability to maintain medical condition in home without hospitalization, ER visit, or unplanned physician visit since last RN visit.
- D. Verbalizes S/S to report to RN or physician and those that are an emergency and require immediate medical attention (i.e., Call 911).

**PLAN for NEXT VISIT: Advance to Step 3 (unmet outcomes move forward)**

*If Interventions are not done or outcomes met during the encounter, explain WHY – since it is the STANDARD = ACCOUNTABILITY every visit*

**Care Plans VS Pathways**

- **Care Plan**
  - List of Interventions & Outcome BY EPISODE

- **Pathway**
  - Planned Interventions that GUIDE the care & Outcomes that DRIVE the care BY VISIT / ENCOUNTER
Early Results

Before
• Care Plans

After
• Clinical Pathways

BENEFITS: Decrease & Control Costs

Reduce & Control Costs
• Less variability in care and costs between care providers and clients with similar conditions
• Reduce #Visits & LOS
• Reduce Hospitalization
• Less Outliers (↑ predictability & control of costs)
Diabetes Pathway 5 Agency STUDY (mid 90’s)
Carolyn Mull, Ph.D., RN
Aurora University, IL

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Non-Pathway</th>
<th>Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>63</td>
<td>66</td>
</tr>
<tr>
<td>Age</td>
<td>71</td>
<td>64</td>
</tr>
<tr>
<td>Visits</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>LOS</td>
<td>213 (SD+304)</td>
<td>35 (SD+28)</td>
</tr>
<tr>
<td>Hosp Readm</td>
<td>0.250</td>
<td>0.164</td>
</tr>
<tr>
<td>Outcomes</td>
<td>44% (7/16)</td>
<td>63% (10/16)</td>
</tr>
</tbody>
</table>

Pathway Community Surveys (2001)
Nursing Visits

(Chronic Cardiac & Diabetes)

- Chronic Cardiac (ICD-9 codes 410-429)
- Diabetes (ICD-9 codes 250-259)
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↓ Length of Stay

![Length of Stay Graph](image)

- Chronic Cardiac (ICD-9 codes 410-429)
- Diabetes (ICD-9 codes 250-259)

1994 Pre-Pathway
1995 Post-Pathway
2001 Pathway

MHC (2000-2001)
Acute Care Hospitalization 31 to 28

![MHC Graph](image)

Source: Missouri Home Care, Auxi Health Company
VNA First User Conference Presentation May 2002
ACH – 2002 (23 /32 Ref)

Compared to Reference

Source: Missouri Home Care, Auxi Health Company
VNA First User Conference Presentation May 2002

Emergent Care Services (21/26)

Compared to Reference

Source: Missouri Home Care, Auxi Health Company
VNA First User Conference Presentation May 2002
Medical Professionals

Graph 22 of 22 How often home health patients had to be admitted to the hospital.

This information comes from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period April 2011 - March 2012

Best Practices, Proactive Outcome Improvement
Integrated into Workflow

It’s not just about the expected or planned action, it’s about how it gets prompted to be done within the workflow = checks and balances … on the fly!
HHQI - Public Reported OASIS Outcomes

- Hospitalization
- ER
- Ambulation
- Transferring
- Bathing
- Dyspnea
- Pain
- Surgical Wound
- Medications

HHQI Reported OASIS Process Indicators

- Medications
- Timely Care
- Flu & Pneumonia
- Wound Risk & Prevention
- Fall Risk
- Heart Failure Symptoms Treated
- Diabetic Foot Care
- Pressure Ulcer Prevention
- Pain
- Depression
### HHC CAHPS® Survey & Pathways

| Continuity / Plan | 2. Tell you what services you would get  
|                  | 9. Did HH providers seem informed/up-to-date |
| Safety           | 3. Talk with you about how to set up safe home |
| Medications      | 4. Talk with you about all prescription and OTC  
|                  | 5. Ask to see all prescription and OTC meds  
|                  | 12. Talk about purpose of new/changed meds  
|                  | 13. Talk about when to take meds  
|                  | 14. Talk about side effects of meds |
| Pain             | 10. Talk about pain |
| Education        | 17. Explain things – easy to understand |

### Demonstrate Evidence-Based Practice (EBP)

- JCAHO / CHAP
- QIOs, IHI, Etc.

- Prevention
- Self-Care
- Medication
- Diet
- Exacerbation
- S/S HF
- WT, Edema, Dyspnea, Ox
- Safety
- Activity
- Labs

**Heart Failure**

**Care Transitions**

**Best Practice**

**Condition – Specific EBP**

*The Gold Standard*
VNA FIRST Home Care Steps® Protocols

An Evidence Based Standardized Care Approach

Building Blocks

EBP - Core Disease Management Content

Assumptions (ACH, Fall, Med, Comorbids)

Core Disease Management Interventions & Outcomes
- Disease process
- Tests/Treatments
- Medication management
- Nutrition/hydration/elimination
- Activity
- Safety
- Psychosocial
- Interteam/Community

Source: VNA FIRST Home Care Steps® Protocols
EBP – Condition-Specific Content

Integration of Condition-Specific Best Practice

• Examples - Diabetes
  • Diabetes Medical Practice Guidelines from the Agency for Healthcare Administration
  • American Diabetes Association Clinical Practice Recommendations & Standards of Medical Care for Patients with Diabetes
  • American Dietetic Association
  • American Association of Clinical Endocrinologists
  • AHRQ - Agency for Healthcare Research and Quality (EBP)
  • CHAP, JCAHO, ACHC
  • HHQI Outcome and Process, CAHPS
  • QIO, Care Transition, Teach Back, AIM, Project RED, etc

Visit Note: Compliance with best practice

Step by Step: Consistency in care, focused care, predictable care

Source: VNA FIRST Home Care Steps® Protocols

VNA First Disease Management Model

Health Promotion
8-9

Disease Control
4-7

Safety
1-3

High Level of Self-Care

Patient Empowerment

Source: VNA FIRST Disease Management Model
PROMOTE BEST & EVIDENCE-BASED PRACTICE

WITHIN THE WORKFLOW

With Step by Step

CLINICAL PATHWAYS

Interventions that GUIDE the Care and

PATIENT/CG Outcomes that DRIVE the Care

Clinical Pathway Model

Workflow Example
Plan for Visit

Plan for Visit: Advance to CHF Step 2 >>
Task: Labs: CBC >>
Care Summary/Modified SBAR

Best Practice - Continuity
Hand-off
Patient Centeredness
CAHPS continuity

CHF Step 2 Interventions & Outcomes

CHF Step 2

Interventions >> see all

Outcomes >> see all

Disease Process

- Assess/verify patient identity with name and date of birth, if new to homecare associate.
- Assess circulatory/cardiac status: VS; heart rate/rhythm; orthostatic BP, weight, edema; note change in status.
- Assess level of dyspnea with activity and at rest, not change in status.
- Evaluate knowledge of S/S to report to RN/Physician and those that need immediate medical attention. (Refer to Zone/Red Flag Plan). Use Teach Back Method to determine comprehension. Ask patient to repeat IN THEIR OWN WORDS.

- 1. Demonstrates no new, worsening continued S/S outside normal range at anytime during the visit
- 2. Or since last visit.
- 3. Demonstrates ability to maintain medical condition in home without hospitalization, ER visit, or unplanned physician visit since last RN visit.
- Provide contact phone numbers and who to contact during evenings and weekends for symptoms/concerns.
- Condition – Specific EBP

Source: VNA FIRST Home Care Steps® Protocols

Outcomes: TEACH BACK
### CHF Step 2 Interventions & Outcomes

#### Disease Process
- **4.** Verbalizes importance of good skin care and S/S of skin breakdown to report.

#### Tests / Treatments
- **V N** Perform tests as ordered.

#### Medications
- **V N** Instruct on definition of disease process and basic treatment goals.
- **V N** Instruct on importance of good skin care to edematous areas; s/s of skin breakdown and what to report.
- **V N** Perform treatments as ordered.
- **V N** Instruct on importance of good skin care to edematous areas; s/s of skin breakdown and what to report.
- **V N** Instruct on definition of disease process and basic treatment goals.

#### Care Transitions
- **5.** Verbalizes importance and need for a simple plan/system in place for taking medications.

#### CAHPS
- **6.** Verbalizes purpose, action, level of effectiveness, side effects, and when and how to report problems with medication/supplement(s) instructed this visit.

#### OASIS Process
- **V N** Instruct on strategies to improve medication self-administration, including pill box and simplification plan to support a manageable system and compliance.
- **V N** Instruct on any medication/supplement changes; purpose, action and side effects and how to monitor effectiveness of one or two medication/supplements when to report medication problems.

#### OASIS Outcomes
- **V N** Instruct on strategies to improve medication self-administration, including pill box and simplification plan to support a manageable system and compliance.

#### Plan for Next Visit:

**Autopopulated based on outcomes**

**Plan for Next Visit:** Advance to CHF Step 3 >>

**Task:** Follow-up: Labs: CBC

**Care Summary/Modified SBAR (Autopopulated)**

Best Practice - Continuity

Hand-off

Patient Centeredness

CAHPS continuity
Ensure Proactive Care & Improvement

- Workflow Clinical Alert Notices of declines, lack of progress that trigger recommendations and follow-up
- Adverse event prevention – risk identification, plan
- Process alerts in the workflow, with escalation to QI dashboard – no need for random chart reviews
- No waiting for case manager in office to identify issue/need, field staff are triggered to take action TODAY

EMPOWER THE PATIENT
Patient Education Tools

Demonstrate Tools that assist the patient to DRIVE THEIR CARE & PREVENT ACH!

EMPOWERED ACTIVATED PATIENT
Support Self-Management
Step by Step Patient Ed Guides

√ Health
Promotion

√ Disease
Control

√ Safety

Congestive Heart Failure

Source: Eventium’s Step by Step Guides

A Pathway for the Patient/CG!

CHF Step 2

S/S
Meds

Care Transitions

CAHPS
- Meds

Patient-Centric

Source: Eventium’s Step by Step Guides

Syptoms of CHF
- Swelling in your ankles and legs
- A cough that will not go away
- Always being tired
- Shortness of breath
- Compulsory weight gain
- Serum Creatinine (Cr) > 1.5
- Remnant fraction (Cr) > 25%
- Urinary tract infection
- Your heart pumps blood to the rest of your body. Your heart makes it work. You have muscles in your heart. The heart becomes weakened, so as to perform. A special system enables this.

Skin Care
If your skin is torn, you may get sick. Take good care of your skin and prevent scarring. (See Skin Care, page 106)
If your skin is torn, you may get sick. Take good care of your skin and prevent scarring. (See Skin Care, page 106)

Exercise and Activity
- Take your medication exactly as directed. Never skip doses. Never change the amount of any medication. Always report all changes to your physician.
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Best Practice

Condition – Specific EBP

Exercise and Activity
- Take your medication exactly as directed. Never skip doses. Never change the amount of any medication. Always report all changes to your physician.
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## Symptom Logs: Critical Aspects of Self Management

- **Symptom Logs** – included in Step by Step Books
- **Patient tracks own**
  - Symptoms
  - Activity Level
  - Diet
  - Dyspnea
  - Pain
- **Keeps patient active in their care**
- **Can take to their physicians**

### Congestive Heart Failure Zones for Management

#### Green Zone: All Clear
- Your Goal Weight:
  - No shortness of breath
  - No swelling
  - No weight gain
  - No chest pain
  - No decrease in your ability to maintain your activity level
- **Green Zone Means**: Your symptoms are under control

#### Yellow Zone: Caution
- If you have any of the following signs and symptoms:
  - Weight gain of 3 or more pounds
  - Increased cough
  - Increased swelling
  - Decrease in breath with activity
  - Increase in the number of pillows needed
  - Anything else unusual that bothers you
- **Yellow Zone Means**: May indicate that you need to be evaluated by a physician

**Action Oriented**
- Call your healthcare provider if you are going into the **RED zone**

#### Red Zone: Medical Alert
- **Red Zone Means**: Need to be evaluated by a physician immediately

### OASIS Outcomes

- **S/S**
- **OASIS**
  - Short of breath
  - Swelling
  - Fever
  - Difficulty in swallowing
  - Activity Level
  - No Problem

**Condition – Specific EBP**

**Care Transitions**

**Source:** Eventium’s Step by Step Guides
Universal Medication Schedule

CAHPS - Meds

Meds

Medication Simplification

Best Practice

Care Transitions

Source: Eventium's Step by Step Guides

Step 3 – Continue w S/S & Med Focus

TEACH BACK!

GOALS

1. Today your outcomes and test results are within your goal range and you and your healthcare provider. Tell your daily Digoxin 0.25mg Daily

2. If your daily Digoxin 0.25mg is not tolerated every day, then you can have a doctor's prescription. The daily Digoxin 0.25mg is not tolerated every day.

3. If your daily Digoxin 0.25mg is not tolerated every day, you can have a doctor's prescription. The daily Digoxin 0.25mg is not tolerated every day.

4. Today your outcomes and test results are within your goal range and you and your healthcare provider. Tell your daily Digoxin 0.25mg is not tolerated every day, then you can have a doctor's prescription.
Care Plans VS StepByStep Clinical Pathways

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Care Plans</th>
<th>Clinical Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician – Driven</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Patient – Driven, Outcome – Driven</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>High level of variance in the care that is provided. Difficult to predict care and care needs.</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Standardized Care – Minimal variance in care, less outliers, controlled cost and more predictable outcomes.</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Problem – Oriented Care</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Proactive – Preventive Care</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Limited ability to evaluate effectiveness of services at the point of care (during visits)</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Evaluation of effectiveness of service is done every visit – high level accountability</td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>

Lastly, How Pathways Help Defend Care through Documentation

- Proactive Alerts & Reports
- Workflow Alerts if at risk of not meeting CoPs
- Care Defense (CoP/G-Tag) Report
- State Surveys
- CoPs Integrated
- Compliance
- Avoid Medicare Fraud Abatement Efforts
- QIC/PSC/ZPIC/ALJ/MAC/RAC/H.E.A.T
- Outcome – Driven = Care Defense
**OUR Story** – Post Clinical Pathway

- **Staff Response**
- **QI / Ed Time Savings**
- **Resource Use / Costs**
- **HHQI Process - MEDS**
- **CAHPS - Satisfaction**

**Upper Peninsula EXPERIENCE**

**Care Models & Patient Ed Tool**

- Pre – Care Plan/Pathway Model and Patient Education tools
- Post – Pathway Model and Patient Education Tools

**Reasons for Selecting New Model of Care**

- Difficult to maintain content in current model, costly
- Moving to EMR from paper. EMR offered Pathway Model
- Pathway Model in EMR was recognized best practice in the industry
- Needed to be able to demonstrate evidence-based, standardized care to potential partners
Implementation & Staff Response

• Reaction
  • New SNs to home care
  • Seasoned SN

• Issues
  • Related to hardware issues and connectivity

Results: QI / Education Time Savings

• Training / Orientation of new employees with NO home health experience is easier – with the use of a standardized care model that directs care at the visit level

• Recruitment tool

• Quality reviews are more efficient with the use of a standardized care model within an electronic record
RESOURCE USE

• Cost of Care

↓ Office Patient Care Coordinators

Moved 2 RN FTE’s from office into the field

Moved patient management from in the office to the field

• Pathways provide proactive care management at point of care
• No delay in identifying need for change in service or evaluating effectiveness of care
• No waiting for a scheduled patient care conference
SN Productivity (# Visits per day / FTE)

- In the midst of NEW EMR implementation and NEW Clinical Pathway Model implementation
  - Productivity decreased by only 0.13 visits per RN FTE

Census Up, SN Visits Down

9/30/2013 Census ave 200, Visit/week ave 290
= sustainability of cost effective care
# Visits/Episode, Standard Deviation

<table>
<thead>
<tr>
<th># Visits/Episode</th>
<th>Standard Deviation</th>
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<tbody>
<tr>
<td>Q4 2012</td>
<td>12.55</td>
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<tr>
<td>Q1 2012</td>
<td>18.39</td>
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<tr>
<td>Q1 2011</td>
<td>19.95</td>
</tr>
<tr>
<td>Q4 2011</td>
<td>5.7</td>
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<tr>
<td>Q1 2012</td>
<td>6.84</td>
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SN Direct Costs per Episode

<table>
<thead>
<tr>
<th>Cost per Episode</th>
<th>Q4 2012</th>
<th>Q1 2012</th>
<th>Q1 2011</th>
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<tbody>
<tr>
<td>$983.00</td>
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<td>$1,207</td>
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<td>$1,344</td>
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### Episode Costs = $avings
*Decrease from Q1 2011 to 4Q 2012*

| ↓ $381/Episode | • x 1472 Episodes (2012) |
| ↓ $140,208/Quarter | • = $560,832/year! |

### ADRs
- # ADRs: 5
- $ Returned: $0
OASIS - PBQI

PROCESS – Indicators

Med Ed, Vaccines, Depression
OASIS – PBQI Process Results Q2 2013

• Q2 2013 All Patients Process Quality Measures Report

HHQI – CAHPS – SATISFACTION
OASIS OBQI

OUTCOMES

Impact of Pathways on ER Use & Hospitalizations

Agency Data ER Q1 2011 to Q2 2013
Agency Data **ACH** Q1 2011 to Q2 2013

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<table>
<thead>
<tr>
<th>Quarter</th>
<th>Hospitalization</th>
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<tr>
<td>Q2 2013</td>
<td>16.6</td>
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<td>Q1 2012</td>
<td>11.7</td>
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<td>21.8</td>
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**MARKETING STRATEGIES & EXPERIENCES**
Meet ACO Needs with Pathways

NAHC October 2013

Thank You!

Clinical Pathways
Premier Partner
Triple Aim

Quality Care
- Proactive Care
- Transitional Care Expertise
- Clinical Pathways
  - Best Practice
  - Step by Step Patient Education
  - Patient's drive the care

Healthy Community
- Predictable Outcomes
- Sustained Outcomes
- Preventive Care Focus
- Empowered, Activated Patients!

Cost Effective Care
- Efficient, focused care
- Decline in Hospitalizations and ER Visits
- Controlled, standardized care
- Less outliers

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