How to Improve Bottom Line and P4P Outcomes during Declining Reimbursement: Utilize Standardized Point-of-Care Workflows with Clinical Decision Support, QA and QI

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Outline

**Introduction**

- State of affairs of homecare reimbursement, costs and challenges

**Episode management – current typical activities**

- Non-revenue-generating clinical and QI staff
- Direct care clinicians

**Financial impact: agency case study pre and post-implementation of standardized step-by-step point-of-care clinical pathways**

**Demonstration of standardized care model with clinical decision support (CDS)**

- Best practice integration, demo of workflow, clinical decision support, reports

**Impact of standardized care and CDS on episode management activities/workflows**
**OUR Story:**
Implementing Clinical Pathways

Eroding Margins

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**Why We Needed To Change**

**Our Previous Care Model & Tools**
- Paper Pathway Model and Less-Integrated Patient Education tools

**Reasons for Selecting New Model of Care**
- Difficult & Costly to maintain content in current model
- Moving from paper-based to EMR-based
- EMR-based Pathway was recognized best practice in the industry
- Needed to demonstrate evidence-based, standardized care to potential partners

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**Staff Response**

- **Staff 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
- Removes Major Source of Variance: Standardized Care Plans for all Nurses on all Visits
- Quality reviews are more efficient with the use of a standardized care model and associated reports within an electronic record

RESOURCE USE / COST OF CARE
RESOURCE USE / COST OF CARE

• Moved Case Management to the Field
  – 2 FTE Office RNs (15% of all Nursing)
• Reduced Service Plan (Visit Frequency)
SN Direct Costs per Episode

$1,344

$1,207

$944

$813

Q1 2011
Q1 2012
Q1 2013
Q1 2014

Decreased Episode Costs = $avings

(Decrease from Q1 2011 to Q1 2014)

$530/
Episode

= 30% of all Costs!

= $596,600/year

↓ $149,150/
Quarter

• x 1125 Episodes (2013)
• Discuss productivity and staff usage

- ADRs
  - # ADRs: 15
  - $ Returned: $0
OASIS-C – PBQI
PROCESS INDICATORS

IMPLEMENTATION DATE

Timely Initiation of Care
OASIS OBQI

OUTCOMES

Impact of Pathways on ER Use & Hospitalizations
IMPLEMENTATION DATE

- National Reference
- Improvement in Surgical Wounds

IMPLEMENTATION DATE

- National Reference
- Improvement in Confusion Frequency
HHQI – CAHPS – SATISFACTION
CAHPS – Medications (Current Data)

- 4. Talk About Medicines You Are Taking (% Yes)
- Ask to See Medicines (% Yes)
- Talk About Pain (% Yes)
- Talk About Side Effects of Medicines (% Yes)

CAHPS – Listening, Help, Respect (Current Data)

- Treat You About Care and...
- Treat you Gently As...
- Explain in a way you...
- Listen Carefully to You (%...
MARKETING STRATEGIES & EXPERIENCES

Solution: Minimize Cost with Episode Management at the Point-of-Care

Standardized Step-by-Step Pathways with real-time CDS
Success Strategies

Documentation...Documentation...Documentation

- Assures compliance

Episode management

- Standardized step-by-step care
  - Point-of-care accountability via clinical and process alerts
  - Controlled, managed care
  - Patient-driven, outcome-driven
  - Insight into population management
- Real time alerts and reports during episode
  - G-tag compliance
  - Physician order compliance
  - OASIS outcome decline
  - Population analysis reports – cost and variance
  - Case management reports – clinical severity vs productivity and outcomes

Example: standardized care model

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
Care Plans VS Pathways

- List of Interventions & Outcomes BY EPISODE

Pathway

- List of Interventions & Outcomes BY VISIT / ENCOUNTER

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 definitions of disease process and basic treatment goals.

- Instruct on importance of good skin care to edematous areas; signs of skin breakdown and what to report.

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

- 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.

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

Nut/Hyd/Elim

\* Step 2
\* Instruct on diet/ fluid restrictions
\* Verbalizes general dietary restrictions
\* Safety

\* Step 5
\* Instruct on how to calculate sodium content of food/fluids
\* Verbalizes how to calculate sodium content of food/fluids
\* Disease Control
\* Demonstrates compliance with diet/fluid requirements

\* Step 8
\* Instruct on selection of appropriate restaurant foods
\* Verbalizes knowledge of appropriate restaurant foods
\* Health Promotion

CHF Step 3 Interventions

**PLAN for VISIT: CHF Step 3**

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

**Instruct on how to calculate sodium content of food/fluids**
**Verbalizes how to calculate sodium content of food/fluids**
**Disease Control**
**Demonstrates compliance with diet/fluid requirements**

**Instruct on selection of appropriate restaurant foods**
**Verbalizes knowledge of appropriate restaurant foods**
**Health Promotion**

**ALL interventions are expected to be completed and outcomes met. If they are not, then need to indicate reason WHY with a Variance code.**

**Define variance from THE STANDARD = ACCOUNTABILITY every visit.**

**PLAN for NEXT VISIT: Advance to Step 4**
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**

Underlying Standard + Defined Variance = Population Management
Increase Audits, Paybacks, Penalties

QIC/PSC/ZPIC/ALJ/MAC/RAC/H.E.A.T
- Face to face
- Physician order compliance

State surveys

Accrediting body surveys

HHQI report cards, P4P
- Outcome, Process, Satisfaction

Impact on viability, must be low risk
- Marketing
- Partnerships

Uncontrolled Episode Costs

Lack of standardization at the point-of-care
- Lack of population management
- Excessive outliers, LUPAs
- Unpredictable costs
- Unpredictable outcomes
Increase Cost

↑ QA, Oversight cost to ensure compliance
- Education staff – orientation
- Clinical management
- QA/QI staff
- Consultants

↑ Expense for third party scrubbers/analytics

Rebasing Success Strategies

Opportunities to improve clinical, operational, and financial outcomes:
- Reduce care variance
- Reduce avoidable LUPA episodes
- Improve discipline utilization and management
- Improve OASIS HHRG reflecting planned care
- Investigate DM programs that will enhance care delivery

**Episode Management: ↑ $**

Focus: Outside visit episode management activities

**Care Management: Challenges**

<table>
<thead>
<tr>
<th>Care Management</th>
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<tr>
<td>• No Standardization - variability in care</td>
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<tr>
<td>• Inefficient and inconsistent care planning</td>
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<tr>
<td>• Higher % of LUPAs or Outliers</td>
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<tr>
<td>• Lack of accountability at the point of care</td>
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<tr>
<td>• Reactive care VS Proactive and Preventive Care</td>
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<tr>
<td>• Retrospective Care Analysis (too late to take immediate action)</td>
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<tr>
<td>• High Rate of ER and ACH during episode</td>
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<tr>
<td>• Declines in OASIS outcomes</td>
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<tr>
<td>• Ineffective visits, lack of change in care plan</td>
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<tr>
<td>• Lack of standardized patient education tools – limited participation in care</td>
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<tr>
<td>• Lack of continuity in care, difficult to quickly identify unique needs, re-teaching same content = ineffective visits</td>
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Plan Of Care Oversight: Challenges

**POC Oversight**

- Plan of Care often does not accurately reflect patient’s needs
  - Case Mix does not accurately reflect Service/Utilization
  - Difficult to show compliance with G-Tags, Physician Orders
  - Care is difficult to defend → penalties and pay-backs
- Heavily utilized in-office Case Managers, Clinical Managers, QA/QI staff
- POC analysis is delayed, retrospective at IDTM mtg, random or Post-Discharge
- Identifying new documentation requirements, EBP and Best Practices is labor intensive and difficult to implement and enforce
- EHR technology limitations (internet/device reqs., clinical workflow and content doesn’t fit into existing EMR structure)
POC Oversight: Challenges

Typical Workflow

- Extensive review of OASIS, ensuring correct Care Plan
- Random, Retrospective Chart Audits
- IF Patient is still in-service: make change in care plan
- Educate Clinician for future reference
- Documentation of follow-up communication and action is typically lacking

Team Collaboration: Challenges

- No standardization in criteria for use of disciplines (SN, PT, OT, SLP, MSS, RD, HCA)
  - Lack of evidence for need for specific disciplines
  - Disciplines working in a silos
  - Hand-offs between the same discipline or different disciplines are fragmented
  - Lack of continuity
  - Unnecessary re-assessments, inefficient visits
  - Duplication of services
- Lack of accountability for interteam communication at POC
  - Overdue interdisciplinary communication
  - Lack of documentation of telephone or in-person interteam communication
History

Team Collaboration: Challenges

- Disciplines are Siloed
- Hand-offs are fragmented

Discharge Planning: Challenges

- Lack of consistent discharge (CARE TRANSITION) criteria
- Lack of clinical decision support for discharge recommendations based on clinical findings
- Lack of evidence supporting need for planned visits (resource use) or for continued services in higher LOS cases
- Payer, Agency or Clinician driven care VS Patient-driven care
- Significant variance in number of visits or resources used for similar patients
- Significant variance in numbers of planned visits (resource use) vs actual visits (resource use)
  - Low predictability in resource needs / cost for similar patients
Discharge Planning: Challenges

Subjective Clinician – Driven Discharge Planning across Case Managers = Outliers without clear reason for variance

- Similar Patient Discharged: < 4 visits
- Similar Patient Discharged: 12 visits
- Similar Patient Discharged: > 19 visits

Clinical Outcomes: Challenges

- Lack of accountability at POC, delaying evaluation of effectiveness of care
  - Lack of real-time evaluation of findings, outcomes
  - Delayed or missed opportunity to intervene and modify care that promotes outcome improvement
  - HHQI Outcome evaluation occurs AFTER OASIS submission, eliminating ability to improve during episode
  - HHQI Process Indicator evaluation: discrepancies in documentation, time consuming and not evaluated until AFTER OASIS submission
- Lack of Patient-Centric, Outcome-Driven care
  - Payer, agency, clinician driven care
  - Lack of standardized patient education tools
Clinical Outcomes: Challenges

<table>
<thead>
<tr>
<th>Site A</th>
<th>Site B</th>
<th>Site C</th>
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- No Standardized Care

<table>
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<tr>
<th>Outcome</th>
<th>Reason Why:</th>
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<tr>
<td>Improved</td>
<td>?</td>
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<tr>
<td>Unchanged</td>
<td></td>
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<tr>
<td>Declined</td>
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QA/QI: Challenges

- QA – Quality Assurance, Labor intensive, Costly
- Best practice, EBP, Payer and Accrediting Agency requirements not embedded into the POC workflow
  - Compliance monitoring is time consuming
  - Retrospective, random auditing – too late to change care or improve outcomes or processes
    - Appropriateness of care, no standard
    - Effectiveness of care, no standard
    - Documentation best-practice, no standard
    - Best-practice, EBP compliance
    - Physician order compliance
    - Defensible care documentation
    - G-Tag compliance
QA/QI: Challenges

- QI – Quality Improvement, difficult to focus on when QA is labor intensive and costly leading to preventable declines, poor documentation, care processes and clinical outcomes
  - $ is spent on QA activities, not on program, staff or patient improvement activities, equipment or necessary marketing/advertizing
  - QI is not embedded into the workflow, retrospective after care processes have become a pattern
  - Clinical – patient improvement
  - Process - clinician improvement

Typical distribution of QA vs. QI activities
CMS compliance G-Tags

- G108 Advance notice of care & changes to plan of care
- G101 Inform, promote & protect patient rights
- G109 Participate in planning of care & treatment
- G144 Documentation shows effective care coordination
- 484.30 Condition: Skilled nursing services

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 S/S TREATED
- DIABETIC FOOT CARE
- PRESSURE ULCER PREVENTION
- PAIN
- DEPRESSION

HHC CAHPS® Survey

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)**

Accrediting Organizations

- Prevention
- Self-Care
- Safety

QIOs, IHI, Etc.

- Medication
- Diet
- Exacerbation
- S/S HF WT, Edema, Dyspnea, Ox

**The Gold Standard**

- Care Transitions
- Best Practice
- Condition – Specific EBP

**Home Care Steps® Protocols**

*An Evidence Based Standardized Care Approach*

Building Blocks
Best Practices, Payer Requirements, 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!

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
  - CoP G Tags, HHQI Outcome and Process, CAHPS
  - QIO, Care Transition, Teach Back, AIM, Project RED, etc

Visit Note: Compliance with best practice, requirements

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

Source: VNA FIRST Disease Management Model

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
- Demo - Workflow

Pathways: standardized managed care tools & robust data = ↓ $, variability, risk

- Demo – Reports

Robust Point-of-Care Documentation + CDS Algorithms = Alerts, Recommendations, and Effective Dashboards

Proactive
Real – Time
EMPOWER THE PATIENT
Patient Education Tools

Standardized Tools

↑ Pt – driven care

↓ ACH

↓ $ episode

EMPOWERED
ACTIVATED PATIENT

Achieve goals, less resources w/
Standardized Patient Ed Tools

A Pathway for the Patient/CG!
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

Source: Eventium's Step by Step Guides
Episode Management: \( \downarrow \) $olutions

QUALITY ASSURANCE/IMPROVEMENT

CARE MANAGEMENT

OPTIMUM CLINICAL OUTCOMES

PLAN OF CARE OVERSIGHT

DISCHARGE PLANNING

TEAM COLLABORATION

Focus: Point-of-Care episode management activities

Care Management: At the Point-of-Care

Standardized Care: Clinical Pathways

- OASIS SOC
- Episode Planning
- Resource Needs
- Visit Frequency
- Physician Orders
- Plan for Next Visit
- Visit Documentation
- Implement Care Plan
- Patient Readiness
- Evaluate EOC & Discharge Readiness
- Create Care Plan
- IDT Care Coordination

Back
POC Oversight: Workflow Alerts, Reports

Standardized Workflow

- RT Clinical & Process alerts in WORKFLOW
- CM Dashboard RT Clinical
- CM RT Process Best Practice
- QI Review RT Order
- QI Review RT G-tag

Team Collaboration: prompted in field

Patient – Driven Standardized Care

Team Coordination

- IDT Communication Loop
- Evaluate IDT
- Implement Care Plan
- Physician Orders
- Visit Frequency
- Care Coordination
- Resource Needs
Discharge Planning: **At Point-of-Care**

Standardized Patient-Driven Discharge Criteria = Controlled Results Across Similar Patients

**Similar Patient Discharged:**
- 10 visits

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Clinical Outcomes: **At Point-of-Care every visit**

Outcome:
- Improved
- Unchanged
- Declined

Site A | Site B | Site C
---|---|---

**Standardized Care**

Clinical Pathways (Standard)

RT Clinical Alerts of decline or lack of progress

Variance Trend Report – how patient varied from Standard

Variance Report by Site, by CM, By Clinician
QA/QI: At Point-of-Care every visit

Work Flow:
- **Process Alerts**
  - Pathway/Care Plan best practice
  - Payer/accrediting body requirements
- **Clinical Alerts**
  - Observation finding decline
  - Outcome decline or lack of progress
  - Clinical decision support
    - Recommendation for PRN telephone visit
    - Recommendation for new discipline
- **Escalation to CM**
- **Escalation to QA/QI/Manager**
- **Reports**
  - Adverse Events
  - HHQI Outcomes
  - Physician order compliance
  - G-tag compliance

Standardized Care Paradigm Shift of QA vs. QI activities

Proactive, Real Time — Workflow QA & QI Processes

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**Episode management at point-of-care**

- Reduce variance in care and resource use
- Clinical Alert Notices of declines, lack of progress that trigger recommendations and follow-up
- Recommendations for change in disciplines, visit frequencies, on the fly
- Clinical, Process & Best Practice alerts in the workflow, escalation to Manager/QI — 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
- Ensures compliance: $$ No penalties, paybacks
- $$ Episode management at point-of-care, reduce layers non-revenue generating staff for care management and QA
Standardized care via Clinical Pathway
= Focused visits, higher levels of DM,
  + CDS, QA/QI
  = Population management
  ↓ outliers, less resources
  = ↓episode $

Decrease cost, increase margin
Mid-sized organization ADC ~ 200

Cost savings: $596,600 annual per episode cost savings
Increase margins, happy owner
Improve outcomes, happy patients
More $ for marketing to grow business
More $, benefits for staff, happy employees

Episode management with standardized care and documentation, disease management at the point-of care resulting in confident, profitable, low-risk organization
Thank You!

Questions?

Standardized Care

Clinical Decision Support

Quality Care

• Proactive Care
• Transitional Care Expertise
• Clinical Pathways
• Best Practice
• Step by Step Patient Education
• Patient’s drive the care

Predictable Care

• 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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