Clinical pathways tool can increase productivity, improve outcomes

The following DecisionHealth tool shows two screen shots of Milwaukee-based Eventium's Latitude[™] Clinical Decision Support Software that demonstrate a portion of the software's integration of standardization and best practices into the workflow (*see related story, p. 4*). The module is EMR vendor-agnostic and is available in Android, iOS and iPad, and Windows. Here are a few screen shots demonstrating the integration of standardization and best practices into the workflow, says Lisa Van Dyck, RN, MSN, vice president of clinical product development at Eventium. This clinical module offers both clinical pathways and care plans for acute and chronic conditions for the post-acute space.

Harri	et Heart Female 89 y/o CHF CM: Nancy Nurse PCP: Denny	Doctor SOC: 12/26	/2012 Week: 0/9	,	Deventium							
♠	Admission My Visit Disease Process	Interventions	Assessments	Outcomes	Search							
M	Instruct on signs/symptoms signaling a worsening condition to report to RN/Therapist or MD and those that require immediate medical attention (i.e., Call 911). Refer to Symptom Zones/Red Flags Plan.											
✓	Provide contact phone numbers and who to contact during evenings and weekends for symptoms/concerns.											
✓	Evaluate scores of risk assessments/screenings (wound, fall, depression, nutrition, other), symptom control of secondary condition and need for additions (CoSteps) to primary pathway.											
✓	Other required assessments.											

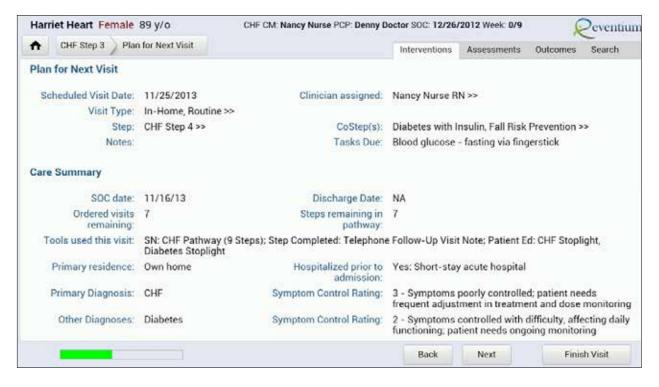
During admission process, interventions are completed and a few additional observations are documented in Latitude, Van Dyck says. Then Latitude analyzes this information and scrubs the start of care (SOC) assessment from the EMR to produce care recommendations that can be accepted, edited or rejected.

larriet Heart F	a search and the second				570.077550.M				~	Leventium	Care recommendations include	
Admission Care Recommendations						Interventions	Assessments	Outcomes	Search	 Clinical pathway or care plan 		
Care Pathway: CHF Co-Steps: 🔽 Diabetes		without Insulin CoStep								 Co-steps for significant other conditions 		
	Telehealth	🔿 Yes 💿	No								▶ Telehealth	
Tel	ephone visits	O Yes 💿	No								 Telephone visits 	
Vist Frequency											 Visit frequency 	
Visit Location:		Week of episode.			Duration:						 Focus assessments unique to p. 	
SN	in-home	1	3	wk	1	C	8					
SN	In-home	2	2	wk	2	C	8				 Care planning components (pro 	
SN	In-home	4	1	wk	3	R	8				flagged as actual problems or p	
					Add					at-risk problems; goals for the		
1222/12/201											episode, etc.	
PRN Visits				000000012	100000							
Amount: Pote	ntial Reasons t	or PRN Visits: Ar	nount: Fr	equency D	uration:							
								Tink	sh Visit			

More information is at: http://www.eventiumusa.com/ihtml/mainFrame.2.ihtml?PAGETOLOAD=qpuserpage_eventiumusa.ihtml&MENUITEMTOLOAD=16700.

CHF Step 3 Plan	n for Visit		10-10-10-10-10-10-10-10-10-10-10-10-10-1			arch		
en orde a View			Interventions	Interventions Assessments Outcomes				
Plan for Visit								
Scheduled Visit Date:	11/22/2013	Clinician assigned:	Contract Con					
Visit Type:	In-Home, Routine >>							
Step:	CHF Step 3 >>	CoStep(s):	Diabetes with Insulin, Fall Risk Prevention >>					
Notes:		Tasks Due:	Blood glucose -	fasting via finge	erstick			
Care Summary								
SOC date:	11/16/13	Discharge Date:	NA					
Primary residence:	Own home	Hospitalized prior to admission:						
Primary Diagnosis:	CHF	Symptom Control Rating:	3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring					
Other Diagnoses:	Diabetes	Symptom Control Rating:	2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring					
High or Moderate Risk Levels:	Fall Risk: High ACH Risk: High							
10			Back	Next	Finish Vis	æ.		

Along with standardized episode management, standardized care is promoted at the visit level with targeted interventions and outcomes, says Van Dyck. Standardization is further enhanced by an automated plan for visit and plan for next visit. The plan for visit is generated from the previous visit based on outcomes achieved and other factors, she says.



An auto-generated clinical summary is included with every generated plan for next visit, says Van Dyck. This includes a brief history, current problems, high risk levels for adverse events, clinical alert summary from current visit, focus assessment summary and status, current progress in planned care including outside resource used, disease management level, and lastly, a list of skilled (ordered) care provided for this visit.