

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.

Harriet Heart Female 89 y/o CHF CM: Nancy Nurse PCP: Denny Doctor SOC: 12/26/2012 Week: 0/9

Admission My Visit Disease Process Interventions Assessments Outcomes Search

- ☐ 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.

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Admission Care Recommendations Interventions Assessments Outcomes Search

Care Pathway: CHF

Co-Steps: ☒ Diabetes without Insulin CoStep

Telehealth: ☐ Yes ☒ No

Telephone visits: ☐ Yes ☒ No

Visit Location	Discipline	Week of episode	Amount	Frequency	Duration
SN	In-home	1	3	wk	1
SN	In-home	2	2	wk	2
SN	In-home	4	1	wk	3

Add

PRN Visits


Amount: Potential Reasons for PRN Visits: Amount: Frequency: Duration:

Finish Visit

Care recommendations include:

- ▶ Clinical pathway or care plan
- ▶ Co-steps for significant other conditions
- ▶ Telehealth
- ▶ Telephone visits
- ▶ Visit frequency
- ▶ Focus assessments unique to patient
- ▶ Care planning components (problems flagged as actual problems or potential at-risk problems; goals for the episode, etc.

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

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CHF Step 3 Plan for Visit Interventions Assessments Outcomes Search

Plan for Visit

Scheduled Visit Date: 11/22/2013 Clinician assigned: Nancy Nurse RN >>

Visit Type: In-Home, Routine >>
 Step: CHF Step 3 >>
 Notes:

CoStep(s): Diabetes with Insulin, Fall Risk Prevention >>
 Tasks Due: Blood glucose - fasting via fingerstick

Care Summary


SOC date: 11/16/13 Discharge Date: NA
 Primary residence: Own home Hospitalized prior to admission: Yes: Short-stay acute hospital

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**

Back Next Finish Visit

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.

Harriet Heart Female 89 y/o CHF CM: Nancy Nurse PCP: Denny Doctor SOC: 12/26/2012 Week: 0/9 

CHF Step 3 Plan for Next Visit Interventions Assessments Outcomes Search

Plan for Next Visit

Scheduled Visit Date: 11/25/2013 Clinician assigned: Nancy Nurse RN >>

Visit Type: In-Home, Routine >>
 Step: CHF Step 4 >>
 Notes:

CoStep(s): Diabetes with Insulin, Fall Risk Prevention >>
 Tasks Due: Blood glucose - fasting via fingerstick

Care Summary

SOC date: 11/16/13 Discharge Date: NA
 Ordered visits remaining: 7 Steps remaining in pathway: 7

Tools used this visit: SN: CHF Pathway (9 Steps); Step Completed: Telephone Follow-Up Visit Note; Patient Ed: CHF Stoplight, Diabetes Stoplight

Primary residence: Own home Hospitalized prior to admission: Yes: Short-stay acute hospital

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

Back Next Finish Visit

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.