

# Shared Care Planning and Coordination:

Provider Case Studies 2016

CASE  
STUDY



SHARED CARE PLANNING AND COORDINATION:  
PROVIDER CASE STUDIES 2016

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LeadingAge Center for Aging Services Technologies:

The LeadingAge Center for Aging Services Technologies (CAST) is focused on accelerating the development, evaluation and adoption of emerging technologies that will transform the aging experience. As an international coalition of more than 400 technology companies, aging-services organizations, businesses, research universities and government representatives, CAST works under the auspices of LeadingAge, an association of 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

For more information, please visit [LeadingAge.org/CAST](http://LeadingAge.org/CAST)

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# 1 Introduction

The LeadingAge Center for Aging Services Technologies (CAST) is pleased to provide the following four case studies highlighting the impacts and benefits of Shared Care Planning and Coordination tools, including care planning, care/case management, care coordination and communications tools. We hope they will demonstrate for providers the benefits of implementing Shared Care Planning and Coordination tools.

The case studies are designed to help long-term and post-acute care (LTPAC) providers understand the benefits that Shared Care Planning and Coordination tools can offer to their care settings. They demonstrate how the use of these tools can result in increased patient/client engagement, increased family/caregiver engagement, improved care planning, improved care coordination, improved care transitions, improved quality of care, improved quality of life and reduced cost of care.

This set of case studies is a companion to the CAST whitepaper entitled [Shared Care Planning and Coordination for Long-Term and Post-Acute Care: A Primer on Planning and Vendor Selection](#). The whitepaper includes a [Shared Care Planning and Coordination Selection Matrix](#) that compares 18 products available for different LTPAC settings with respect to functionalities. Shared Care Planning and Coordination vendors who chose to participate in the self-review were offered an opportunity to nominate a provider to write a case study on its use of the vendor's product.

## 1.1 Case Study Guidelines

CAST provided guidance as well as a template for the case studies to help case study contributors. The template included the following required sections:

- Case Study Category

Impacts and Benefits of Shared Care Planning and Coordination tool, including care planning, care/case management, care coordination and communications tools, in:

- Increased Patient/Client Engagement and Communication around care planning and coordination
- Increased Family/Caregiver Engagement and Communication around care planning and coordination
- Improved Care Planning
- Improved Care Coordination and Data Sharing ability
- Improved Care Transitions
- Improved Quality of Care and Outcomes
- Improved Quality of Life
- Reduced Cost of Care

- Organization Name

- Organization Type (Housing with Services, Home Health/Home Care, Hospice, Attending LTPAC Physician, Adult Day Care/Senior Centers, Assisted Living Facilities, Acute Rehab Facilities, Long-term Acute Care Hospitals, Long-term Care Rehab Facilities, Skilled Nursing Facilities, Intermediate Care Facilities, Intellectual Disabilities/Mental Retardation/Developmental Disabilities (ID/MR/DD) Facilities, Life Plan Communities (formerly CCRC), Program of All-Inclusive Care for the Elderly (PACE))

- Organization Partners (Payer/ Health Plan, Physicians' Offices, Emergency Department, Hospital, Accountable Care Organizations (ACOs), Pharmacies, Others)
- Organization Description
- Project Description
- Shared Care Planning and Coordination System Type (Shared Care Planning Tool; Care/Case Management Tool; Care Coordination and Communication Tool)
- Business Model (Medicare Reimbursement, Medicaid Waiver Coverage, Private Health Insurance Coverage, Private Pay, Standard of Care, ACA-Related Opportunity (ACO, Hospital Readmission Reduction Program, Bundling of Payment, etc.)
- Implementation Approach
- Outcomes (Increased Patient/Client Engagement and Communication around care planning and coordination; Increased Family/Caregiver Engagement and Communication around care planning and coordination; Improved Care Planning; Improved Care Coordination and Data Sharing ability; Improved Care Transitions; Improved Quality of Care and Outcomes; Improved Quality of Life; Reduced Cost of Care)
- Challenges and Pitfalls to Avoid
- Lessons Learned
- Advice to Share with Others

CAST received five completed case studies from nominated providers. We believe that LeadingAge members and other LTPAC providers will benefit from these case studies and learn from other providers who have already selected, implemented, and used Shared Care Planning and Coordination tools.

## 2 Lessons Learned and Advice Drawn from the Case Studies

Several lessons can be learned and advice drawn from the case studies. Below is a summary of lessons learned and advice from others.

### *Planning and Implementation*

- **Ensure to communicate your organization's aims and workflows during the planning and implementation phase.** Communicating your aims and workflows will ensure the technology is being fully leveraged and configurations can be made before the system goes “live”.
- **Consider the software solution's ability to be configured.** To get the most out of a solution take especial interest in the configuration of the software. The software should be flexible enough to meet the specific workflow needs of your organization and beyond.
- **Consider interoperability and the usage of an integration engine if your organization is dealing with multiple practices and multiple EHRs.** Not having interoperability can cause duplicity of effort and wasted time. By using an integration engine to interface with each of the EHR system you can drastically improve efficiency for the coordination team.
- **Consider the infrastructure/connectivity needs of the solution.** Make sure your organization can support the connectivity needs of the solutions. If reliant on wireless connection, ensure adequate coverage onsite and offsite if needed.
- **Make the time commitment required to successfully realize the potential benefits of the solution up front.** Make time upfront to ensure all the relevant information is captured.

### *Training and Support*

- **Set clear expectations for usage of the solution by staff and patients.** Educating the patient on the expectations and obtaining their agreement early on will lead to success.
- **Patients tend to be less eager to participate at times when the technology is introduced to them by non-clinical staff.** It is important to have a trusted clinical source as part of the training team.

The Leaders in Home Health and Hospice Care

## 4 Using Non-Clinical Staff Observations to Support Care Planning and Coordination

### 3.1 *Provider: Home Health VNA (HHVNA)*

**Contributor:** Karen Gomes, Chief Clinical Officer and Vice President of Clinical Services, Home Health Foundation

### 3.2 *Vendor: Care At Hand*

#### *Other Partners*

HHVNA contracts with area hospitals, ACOs, and health plans.

#### *Case Study Category*

- Improved Care Planning
- Improved Care Coordination and Data Sharing ability
- Improved Care Transitions
- Improved Quality of Care and Outcomes

#### *Organization Type*

Home Health

#### *Organization Description*

Home Health VNA (HHVNA) is non-profit home health organization serving cities and towns in Northeastern Massachusetts and Southern New Hampshire. It is the second largest VNA in Massachusetts, offering comprehensive medical and supportive services in patient homes. HHVNA participates in bundle payment programs and its programs are designed to reduce or manage symptoms and avoid unnecessary hospitalizations or re-hospitalizations related to care transition breakdowns.

#### *Project Description*

As a provider that strives to continuously improve performance and outcomes, HHVNA added Care at Hand technology to its care transition process in May 2015. The program serves patients with congestive heart failure (CHF) patients from the time of hospital discharge to home, and for sixty (60) days. An average HVNAA transition program census ranges from 30 to 45 patients.

## Shared Care Planning and Coordination System Type

HHVNA’s care transition program utilizes Care at Hand (CAH) to predict and prevent avoidable re-admissions. The system type is considered a Shared Care Planning Tool, Care/Case Management Tool and Care Coordination and Communication Tool.

CAH is a mobile platform comprised of:

- evidence-based, algorithm-driven, jargon-free surveys conducted in under three minutes by non-medical personnel using a mobile device,
- real-time dashboards supporting rapid quality improvement and strategic program oversight.

## Business Model

HHVNA serves Medicare, Medicaid, private insurance, private pay, and bundled payment arrangements.

## Implementation Approach

Care at Hand surveys are administered by HHVNA coaches in-person and telephonically.

HHVNA coaches are prompted to make observations that are transformed into clinically relevant alerts. Alerts are automatically sent to a program nurse for early detection and intervention of risk factors. Surveys take only two to three minutes and are designed to preserve the integrity of existing therapeutic, human interactions. Approximately one in five surveys triggers an alert. The infographic below summarizes the process.

Evidence-based smart surveys identify EARLY medical and psychosocial warning signs



## Outcomes

During the program period May 2015 through July 2016, HHVNA provided care coordination to 449 patients with the Care at Hand tool. The average age of patients served was 79.4 years and the prevalent clinical diagnosis (69%) was congestive heart failure (CHF).

During this period, 50 admissions were avoided via early detection and intervention.

|   |                            |
|---|----------------------------|
| Estimated savings for 50 avoided re-admissions at national Medicare average (\$13,000)..... | <b>\$650,000</b>           |
| Estimated cost of care coordination.....  | <b>\$78,898</b>            |
| Staff salaries (1FTE coach & 0.25FTE RN.....)   | <b>\$60,938</b>            |
| Technology license fees (\$20 per patient per month, average of 2 months).....              | <b>\$17,960</b>            |
| <b>Benefit to cost ratio.....</b>   | <b>8.24 to 1.00 (824%)</b> |

## *Challenges and Pitfalls to Avoid*

Although Care at Hand surveys are algorithm-driven and simple to deploy, it is crucial for user-organizations and Care at Hand to communicate organizational aims and workflows during planning and implementation of the platform. This increases the achievement of a well-thought out configuration that leverages the advantages of well-chosen, configurable pathways and system-generated tasks, and it helps minimize subsequent workarounds and re-work.

For example, HHVNA indicated that their initial Care at Hand survey should occur on the day of discharge. Care at Hand configured the system to trigger a survey on that date. Unexpectedly, hospitals were discharging patients later in the day and unfinished surveys accumulated overnight. Subsequent staffing and configuration changes were undertaken to improve the situation.

The challenge for the user-organization and Care at Hand is to find time within the organization's busy schedule to collaborate about efficient workflows and make rapid, ongoing quality improvements throughout their service program.

## *Lessons Learned*

Combined with a strong care transition program, Care at Hand moves risk prediction from being episodic to continuous by tapping into the insights of frontline non-medical personnel. Between visits, non-medical staff members are in communication with patients. This opportunity for early identification of medical and psychosocial risk factors promotes timely, proactive care coordination and care management and avoids costly acute care.

## *Advice to Share with Others*

Unlike older technologies that rely on claims or medical records, Care at Hand fills the blind spot between patient encounters in real-time, enabling care teams to identify precursors of health decline while they are still actionable.

The success of this model is attributed to clinical acumen of care transition staff and technology design, peer-reviewed algorithms, granular data capture of clinical factors and social determinants of health, actionable risk predictions, and unique insights of non-medical staff.



## 4 Improving Quality of Care and Patient Engagement/Retention through Outcome-Driven Care Coordination While Generating New Revenue for Providers

### 4.1 *Provider: CareHarmony*

**Contributors:** Gokul Mohan, Manager

### 4.2 *Vendor: eTransX*

#### *Case Study Category*

- Increased Patient/Client Engagement and Communication around care planning and coordination
- Increased Family/Caregiver Engagement and Communication around care planning and coordination
- Improved Care Planning
- Improved Care Coordination and Data Sharing Ability
- Improved Care Transitions
- Improved Quality of Care and Outcomes

#### *Organization Type*

Care Coordination / Care Management Provider

#### *Other Partners*

Physician Practices, Independent Physician Associations (IPAs), Accountable Care Organizations (ACOs)

#### *Organization Description*

CareHarmony is a leading provider of outcome-driven care coordination services for physician practices, Independent Physician Associations (IPAs), and Accountable Care Organizations (ACOs). Located outside of Nashville, TN, CareHarmony specializes in comprehensive, compassionate, whole-person care for chronically ill seniors. CareHarmony offers Chronic Care Management (CCM), Transitional Care Management (TCM), and other value-based care solutions for providers. See [www.care-harmony.com](http://www.care-harmony.com) for more detail.

## Project Description

In 2015, CareHarmony required a comprehensive care coordination technology platform, including a robust integration engine, that could interface with the EMRs (and other systems) of the many physician practices and healthcare organizations it serves. CareHarmony chose the XCare Community platform as the primary care coordination platform to manage its Chronic Care Management and Transitional Care Management patients.

## Shared Care Planning and Coordination System Type

Care/Case Management Tool, Care Coordination and Communication Tool

## Business Model

Both the Chronic Care Management (CCM) and Transitional Care Management (TCM) offerings are covered under the Medicare Physician Fee Schedule

## Implementation Approach

To rapidly deploy the new solution, CareHarmony chose a combination of e-learning and a train the trainer approach for the XCare Community implementation. Prebuilt training materials were used for initial e-training of care coordinators on the new platform. Following initial training, a lead care coordinator was trained in depth on the system and served as the system administrator. The lead coordinator continued to provide other coordinators on-the-job training with the new platform; the ease of the use of the software helped minimize overhead and decrease timelines for implementation and training.

## Outcomes

CareHarmony's skilled clinical team used the XCare Community Platform to deliver more comprehensive, whole-person care for patients, helping make the care coordination program a success for all of CareHarmony's provider clients. The platform, in conjunction with CareHarmony's experienced team, helped deliver the following quality outcomes:

- *Maximized Revenue:* CareHarmony's Chronic Care Management (CCM) solution helps generate new revenues for participating providers. Using the software's care planning and related care coordination tools has helped the CareHarmony team deliver a consistent level of service that meets the requirements of CCM, maximizing monthly billings and revenue generation for clients. The system documents all time spent on patient engagement activities, generating billing documents to improve the accuracy of claim submissions.
- *Increased Patient Retention:* Post implementation of the platform, the retention rate for the Chronic Care Management program increased to over 94% as patients received more consistent, comprehensive, organized coordination. Patients have the option of using a web-based portal and receiving text alerts and reminders, helping them to manage their conditions and stay engaged with their care.
- *Optimized Family/Caregiver Engagement:* The platform allowed coordinators to add and coordinate with family members and caregivers as part of the extended care team for patients. Many seniors have sons/daughters that need to be involved in their ongoing care, and using

a software that helps improve family engagement has strong benefits for the patient's overall health. The solution's web-based portal can be used by patients and their care givers to view educational materials, take surveys, complete assessments, and communicate via secure messaging with authorized care team members or family members. The system also supports an optional feature to schedule and conduct secure video visits between care team members, patients, and family members.

- *Increased Efficiency:* Managing a large panel of patients can be challenging for care coordinators, but the system helped the CareHarmony team scale by keeping track of patients' diverse needs, both clinical and social, and helping the team collaborate to provide the necessary services. The team used the platform's community resource directory to identify, select and order social services, such as Meals On Wheels or transportation, from community-based organizations, reducing the time taken to manage the patient's social needs. Because the platform automatically tracks much of the work the clinical team performs, the team was able to minimize overall administrative overhead and save time documenting their activities.
- *Improved Visibility:* Using the system, management could now have visibility in the day to day productivity (e.g., calls made, time spent, tasks completed, alerts acknowledged) of each coordinator down to the-per patient level. This helped improve effectiveness of huddles and coaching.

### *Challenges and Pitfalls to Avoid*

As with any organization dealing with multiple practices and multiple EMRs, interoperability is a large barrier to delivering effective care. The CareHarmony coordination team routinely has to interact with providers that use different EHRs which can cause duplicity of effort and wasted time. Initially, the clinical team had challenges in having to manually enter information from different EMRs into the care coordination platform. However, eTransX was able to address this issue by using their integration engine to interface with each of the EMR systems. This drastically improved efficiency for the coordination team.

### *Lessons Learned /Advice to Share with Others*

A care coordination platform needs to be robust yet tailored to the clinical team using it. To get the most out of the platform, CareHarmony took especial interest in the configuration of the software. The software proved flexible enough to meet the specific workflow needs of the Chronic Care Management program and beyond. CareHarmony purposefully selected a platform that would work today, not just in a single use case (like Chronic Care Management), but grow with the company as CareHarmony's offerings shift to match the value-based care landscape.

For more detail on how the offering supports seniors see: [www.care-harmony.com/for-patients](http://www.care-harmony.com/for-patients).

## 5 Improving Patient's Self-Management and Outcomes Through Monitoring and Care Coordination

### 5.1 *Provider: Eden Health*

**Contributor:** Travis Tomulty, Regional Care Transition Manager

### 5.2 *Vendor: LG CNS*

#### *Case Study Category*

- Increased Patient/Client Engagement and Communication around care planning and coordination
- Improved Care Planning
- Improved Care Coordination and Data Sharing ability
- Improved Care Transitions
- Improved Quality of Care and Outcomes

#### *Organization Type and Description*

Eden Health provides home health, hospice, and private duty home care services in several states throughout the West Coast of the US including California, Washington, Idaho, and Nevada. This case study is presented from our Home Health Agency branch in Bellingham, Washington.

#### *Other Partners*

Physician's Office - Dr. J. Hopper, Eden Home Health RN - Carrie Warfield and [Interactive Virtual Care Team™](#) technology supported through LG CNS.

#### *Project Description*

The case study is an illustration of home health nursing collaborating with a patient's primary care physician, as well as the subsequent self-empowerment of the patient to achieve greater medical stability and self-management of their chronic disease at home. Also highlighting LG CNS' Interactive Virtual Care Team technology program, managed and coordinated by Eden Health, combined with disease education for skill transfer to enhance patient quality of life.

## *Shared Care Planning and Coordination System Type*

Shared Care Planning Tool, Care/Case Management Tool, and Care Coordination and Communication Tool.

The communication tools utilized involved Eden Health's care coordination and management of the patient's daily in-home self-monitoring through LG CNS' Interactive Virtual Care Team technology and direct communication via phone and fax from Eden Health to the patient's primary care physician.

## *Business Model*

Medicare advantage reimbursement.

## *Implementation Approach*

Implementation is based upon parameters established by the patient's primary care physician for vital sign monitoring implemented with Bluetooth connected blood pressure cuff, pulse oximeter, body weight scale and iPad for data transmission and provider interaction for care management and coordination.

## *Case Study Outcomes*

A 90-year-old female patient, who lives alone, is admitted to home health nursing and therapy services on 5/12/16 based on a referral from her primary care physician. Diagnoses included, but not limited to, diastolic dysfunction, hypertension, pulmonary embolism, chronic kidney disease, essential tremor and diabetes type 2. The patient reports having fallen in her home on 5/2/16 attributed to blood pressure medication changes.

After the home health referral and the primary care physician's visit, the patient purchased a blood pressure cuff and began using it daily, or more, with instructions from the package literature directing her to call to the physician if her blood pressure was outside appropriate parameters. This patient had readings, almost daily, which varied widely between hypotensive to hypertensive and bradycardic to tachycardic; this caused her to take her vitals more frequently trying to get her purchased device to read the same stable reading. Concurrently, the patient was calling her physician frequently; frustrating both the patient and physician.

After consultation, the patient requested Eden Health's virtual care program using LG CNS' Interactive Virtual Care Team technology and implementation began on 6/27/16. Within the first week of initiating virtual care, where the patient is provided with monitoring devices, orientation on device operation, and supervised practice taking vitals during therapy and nursing visits, the patient articulates and demonstrates clinical and psychosocial improvements. The patient's self-reported anxiety was reduced within 48 hours of virtual care implementation and was further evidenced and reiterated by her primary care physician. The patient's physician reviewed her vitals, which were at times out of parameters and thereafter modified the patient's blood pressure medications accordingly; the physician was no longer receiving daily calls regarding the patient's hypertensive and tachycardic vitals. The patient's awareness of acceptable vitals parameters, empowerment of the easy to use tools to measure them, and the reassurance of interactive technology monitoring from home health made a significant impact on the quality of life for the patient.

From the initiation on 6/27/16 of Interactive Virtual Care Team technology to present day, 8/24/16, the patient, safely and gradually, lost 6% body weight as a result of the ability to focus on managing weight, in addition to other beneficial vitals changes. Standard parameters for blood pressure between 100-180 Systolic / 50-90 Diastolic were assigned per patient's physician as well as resting heart rate between 50 and 100 beats per

minute. The patient's profile demonstrates the virtual care alerts have gradually decreased from several per week, to two a week, to one a week, and remained at zero for several weeks. The patient now reports that she feels confident with her new Interactive Virtual Care Team technology program and takes pride in the fact she can do it herself, with the goal of transitioning to complete independence and self-monitoring when she no longer requires home health.

### *Challenges and Pitfalls to Avoid*

Challenges included:

- Educating the patient on daily monitoring expectations and obtain their agreement to ensure success.
- Ensuring wireless coverage and conveying internal operational process to home health team regarding connectivity.

### *Lessons Learned*

By providing Interactive Virtual Care Team technology to patients with chronic diseases who benefit from daily care management, coordination, and health education, we can improve the quality of life while improving medical outcomes for our patients.

Also, a cost-savings benefit to providers is realized resulting from the significant reduction in the frequency of interventions necessary to yield more self-reliant patients with healthy outcomes.

## 6 Improving Communication and Person-Centered Care in Adult Day Using Planning and Coordination Tool

### 6.1 *Providers: Adult Day Care/Senior Center*

**Contributor:** Georgia Gunter, Executive Director

### 6.2 *Vendor: LV Health Solutions Inc.*

#### *Case Study Category*

- Quality of life / satisfaction with care.
- Improving staff efficiencies.
- Reducing healthcare utilization, including hospitalization and hospital readmissions
- Cost of care and return on investment to payers and providers.

#### *Organization Type*

Adult Day Care/Senior Centers.

#### *Organization Description*

Adult Day of Dunwoody is an adult day health services center which supports the daily living needs of adults so they can live in their homes and communities for as long as possible. Our person-center approach to care recognizes that each senior can continue to grow as a person by building on strengths and current abilities. Our seasoned staff focus on providing meaningful experiences each day to promote independence, and relieve loneliness and boredom. Our program is designed not only to enrich the lives of our participants, but also to enhance the lives of our families, caregivers, staff, and our community.

#### *Other Partners*

Ability Rehabs - Ability Rehab LLC focuses on outpatient services providing Physical, Occupational, and Speech Therapy in Atlanta and the surrounding Area.

Senior Connections - Senior Connections is a Meals on Wheels agency providing nutritious, daily meals to

seniors throughout the Metro Atlanta area and Macon, Georgia.

Medicaid and Veterans Affairs Departments.

## *Project Description*

Adult Day of Dunwoody was one of four pilot partners to participate in a 26 week pilot study to identify and document any usability issues with the EMA-Care application and provide recommendations for improvement. This was accomplished through a combination of a needs analysis, usability evaluations performed by a human factors specialist, and five user testing sessions scheduled every six weeks by Georgia Tech Research Institute and LV Health Solutions Inc.

Three different types of users were included in the evaluation: professional caregivers, non-professional family caregivers, and care recipients. All three user groups were able to use the EMA-Care application to document and monitor changes in a care recipient's health status.

Several improvements were made to the application over time based on feedback provided by participants and findings from the human factors specialists. Many participants in this user group reported that a computerized tool was a significant improvement over the traditional pen and paper method of keeping notes on a care recipient. However, using the application benefited individuals from all three user groups. Participants from all three user groups reported that using EMA-Care facilitated communication, encouraged interaction between caregivers and care recipients, and led to an increased investment in the care recipient's health.

## *Shared Care Planning and Coordination System Type*

Shared Care Planning Tool, Care/Case Management Tool, and Care Coordination and Communication Tool

The EMA-Care application was developed for the U.S. market by LV Health Solutions based on the French version of the application called ESA PAD. The EMA-Care name comes from Evaluation, Monitoring, Assistance, and Care.

Accordingly, the goals of EMA-Care are to identify the needs and abilities of care recipients, improve or maintain the care recipient's physical and psychological well-being so they can remain independent, and improve care coordination for all care partners.

## *Business Model*

ROI through:

- A tool that empowers residents and their families the needs and abilities of care recipients, improve or maintain the care recipient's physical and psychological needs.
- Focus on Preventive Care reduces patient/resident decline and helps prevent unnecessary hospital readmission and ER trips.
- Guidance for family and care providers as to the appropriate type of facility and care needed: e.g. Independent Living, Assisted Living, or Memory Care.
- Helps transitions in care team in the case of high labor turnover; thereby allowing more time to be spent on providing care.
- Easy way to store medical records confidentially and limit access.

- Easy real-time documentation of care and activities that regulators, family, care staff can review and access.
- Provides Documentation for professional liability insurance carriers; a risk mitigation tool that can lower malpractice insurance premiums.

## *Implementation Approach*

Participants were recruited from several local senior facilities. The care teams for 26 care recipients were recruited to participate in the study. Usability data was collected from 26 participants (18 care team members and 8 care recipients).

For the first interview, participants were asked to provide demographics after consenting to participate in the study. Next, participants responded to interview questions designed to identify challenges in care coordination and unmet needs.

Participants were then given three questionnaires to complete on their own at home after using EMA-Care for at least 7 days. The three questionnaires included open-ended questions about the usability of the application, seven-point rating scales, and four-point Likert items. The four-point Likert items were different depending on the participant's role (caregiver/care team member or care recipient).

For each of the follow-up interviews, participants were asked to complete the three questionnaires once again. The questionnaires were modified so that all questions related to the initial training were removed.

For the final interview, participants were asked to complete a new set of questionnaires designed to capture each participant's overall opinion of the EMA-Care application and identify ways in which EMA-Care had improved care coordination.

## *Outcomes*

Adult Day of Dunwoody signed up to use EMA-Care for current clients after the pilot study.

For all cases there has been an increased client / caregiver engagement and increased communication with staff; an increased family involvement in the life of the care recipients (especially people being out of state; family members who used to not be involved, etc.).

EMA-Care has allowed more thorough assessments, involving all aspect of care from a physical and cognitive stand point. The care plans are much more detailed and easy to implement and follow, allowing the staff to manage their time better and spend more time with our clients. EMA-Care has made it easier and faster to share data with staff. A very good shareable care coordination tool overall. Having a more in depth care plan has allowed care recipients to have additional people involved in their care where analysis are completed before further decline to the patient's health or lifestyle. Care recipients have been recognizing their needed areas of care and have engaged more with their doctors.

## *Challenges and Pitfalls to Avoid*

As with many research study involving human subjects, one participant ended up not participating; others became too frail to attend sessions and continue to participate. It would be helpful to have a dedicated Case Manager to help with the implementation after the initial training is provided, rather than having the

staff doing it. However, it is critical for each organization to develop internal training capacity that fits their operational model. Since staff turnover is common, frequent retraining and demonstration was needed for all the participating organizations.

### *Lessons Learned / Advice to Share with Others*

EMA-Care has created more open communications with the care recipients and the staff to better implement their care at Adult Day of Dunwoody. EMA-Care is an easier tool compared to what was used before. Patients tend to be less eager to participate at times when the technology is introduced to them by non-clinical staff. It is important to have a trusted clinical source as part of the training team.



## 7 Incorporating Preferences for Everyday Living Inventory in EHR to Improve Residents' Participation and Satisfaction

### 7.1 *Providers: Abramson Center for Jewish Life*

**Contributor:** Karen Eshraghi, Vice President of Resident Services

#### *Other Partner*

Penn State University and the Polisher Research Institute

**Contributor:** Kimberly Van Haltsma, PhD

### 7.2 *Vendor: HealthMEDX*

#### *Case Study Category*

- Increased Patient/Client Engagement and Communication around care planning and coordination
- Increased Caregiver Engagement and Communication around care planning and coordination
- Improved Care Planning
- Improved Quality of Care and Outcomes
- Improved Quality of Life

#### *Organization Type*

Abramson is a CCRC that provides the full spectrum of senior life options, including independent living, short-stay rehab, skilled nursing, assisted living, home care, hospice, and adult day services.

#### *Organization Description*

The Abramson Center for Jewish Life is a nonsectarian provider of geriatric care services located in North Wales, PA. It specializes in the full spectrum of senior medical care within a 72-acre campus and throughout the greater Philadelphia community. The Center also provides a metro-wide referral hotline connecting seniors and their families to available community resources, as well as a Geriatric Care Management outreach program that optimizes area seniors' ability to safely remain in their home. Additionally, Abramson operates its own gerontological research group – the Polisher Research Institute – which explores emerging senior-focused topics that include memory disorders and treatments, depression, fall risks, sleep disorders, and individualized care studies.

## *Project Description*

Abramson sought to integrate data from the Preferences for Everyday Living Inventory (PELI) into their patients' electronic medical record (EMR) file and incorporate those preferences into holistic, person-centered care plans – a cornerstone of Abramson's approach. Additionally, Abramson sought to leverage the PELI and activities data for congruency between resident preferences and service offerings across the organization's long-term care, adult day care, and home care.

## *Shared Care Planning and Coordination System Type*

Care Coordination and Communication Tool

## *Business Model*

Standard of Care

## *Implementation Approach*

Following the 2010 CMS update of MDS 3.0 Section F (Preferences for Customary Routine and Activities), the IMPACT Act of 2014 further emphasized the importance of integrated PELI data. Included in the new criteria that care organizations will be judged and reimbursed on is a call to “Accurately communicate the existence of and provide for the transfer of health information and care preferences across all LTPAC settings”.

Abramson and its Polisher Research Institute developed a four-step plan for assimilation and actuation of resident preferences into a holistic care plan. It includes tracking and measurement of the impact of preference adherence, as reflected in residents' activity attendance and satisfaction. These include the following:

- Clinical Assessment – Establish resident's important preferences.
- Care planning – Evaluating & tracking adherence to preferences in care plan.
- Process Measure – Are residents attending preferred activities?
- Outcome Measure – Are residents benefitting from the preferred activity?

The PELI tool Abramson developed is a structured series of conditional, progressively detailed assessments, triggering more specific questions if a general preference is indicated. Conversely, general preferences residents deem as “unimportant” eliminate more specific questions later in the survey (e.g., residents identifying as non-religious are not asked questions specific to denomination or faith concerns).

Utilizing workflow functionality within their EMR platform (HealthMEDX Vision) to help manage integration of responses from the 72-item list, the Abramson team established a Matching Preferred Activity Report. This custom report gives a facility-specific score for any given time period, with color-coded bar charts that allow administrators an at-a-glance overview of preferences that are not being met within a given household, facility, or campus. This allows for the benchmarking of program performance, and early identification of emerging quality ratings trends based on location, household, patient, or preference types.

## *Outcomes*

Currently, Abramson staff perform routine assessments of 270 residents using the PELI tool. Following the implementation of the program, the organization was able to pinpoint residents that were not attending activities that they listed as “Most Important” to them. Those individuals could then receive additional reminders, assistance, or programming options that increased their attendance. This alignment has led to a corresponding increase in overall patient satisfaction of residents in the pilot groups, with around 80% of residents reporting that they are Mostly/Completely Satisfied.

As part of the Polisher Institute’s partnerships, the Abramson’s PELI program has gained exposure through the Advancing Excellence (AE) in America’s Nursing Homes Campaign. Additionally, their PELI tool has been included in an Ohio Medicaid program, which had a July 2016 deadline to factor PELI data into individual facilities’ daily reimbursement rates.

The program was also profiled in the Journal of the American Medical Directors Association (JAMDA) for their success in the AE’s Person-Centered Care (PCC) Preference Congruence quality measure and focus on matching overall activity attendance at with residents’ preferences.

## *Challenges and Pitfalls to Avoid*

Abramson cautions that to realize the full value of incorporating PELI, an investment of time must happen on the front end. A resident preferences program’s success relies on conscientious attention to those resident details. In today’s challenging senior care environment, some organizations may be unable to make the time commitment that’s required to realize the benefits of PELI.

## *Lessons Learned/Advice to Share with Others*

- Interdisciplinary care planning teams generate solutions for overcoming low preference congruence in multiple settings, such as Skilled Nursing, Personal Care, and Adult Day Programs.
- Integrated preferences into a “Roadmap to Recovery” to enhance engagement of self-management of chronic care conditions in Transitional Care and Adult Day Programs.