Jewish Home Lifecare - Who Are We?

Jewish Home Lifecare (JHL) based in New York City is a continuum of care for the provision of aging services.

We service over 14,000 clients annually with over 60% of those clients living in the community.

Our system provides a network of care that includes home care, day care, transportation, Senior Housing, NORC Partnerships, short term sub acute care and long term care.
Data and Technology: Making it Work for Your Organization

Today we are here to share our experience with utilizing technology to enhance our clinical outcomes.

We are using our long term home health care programs as the example to help illustrate the importance of using technology to establish data systems.

Daily we service over 1,000 clients with home care services. This includes RNs, SWs and Therapists providing services in clients homes that drive our clinical outcomes. Lots of data to track.
Origin of Quality Care Initiative

Combine this with the additional motivator that beginning in 2001 with the Quality Initiative, public release of data and benchmarking with other agencies was started.

The goals were to:

· Empower consumers with quality of care information to make more informed decisions about their health care, and
· Stimulate and support providers and clinicians to improve the quality of health care
Origin of Quality Care Initiative

End result: Public release of data in the form of “report cards” as a means to a market driven health care system. This system is used for hospitals, nursing homes and home care agencies.
Provider Concerns: Regarding Report Cards

• Cost of increased data collection and reporting
• Use of imperfect measures
• Potential for increased liability
• Potential for decreased access as providers avoid caring for patients with complicated disorders in order to protect their performance scores
• Security/confidentiality of health data
Leveraging of Report Cards
What did Care Providers Do?

• Widespread implementation of benchmarking tools
  · Severity adjustment of data
  · “We treat sicker patients”

• Detailed knowledge of why certain areas seem problematic

• Public relations plan
  · Damage control or Brand building on areas of strength
Data Knowledge

Benchmarking tools and detailed knowledge of care issues entails an ability to handle large volumes of data as well as the ability to do drill down.

In order to understand and explain results on report cards, an organization needs to have an in-depth understanding of their data and track it consistently prior to the release.

This lead us to an electronic health record with point of care documentation and the ability to run crystal reports directly from our own patient data.
Benchmarking

We decided to design our Outcomes Based Quality Improvement Plan with the goal of benchmarking against ourselves at different periods of time.

For Home Care Providers, OASIS provides the data to measure patient outcomes and to produce OBQI (Outcome Based Quality Improvement) and OBQM (Outcome Based Quality Management) reports.

OBQI and OBQM reports provide feedback to home health agencies on the outcomes of the care they provide. We thought we would share an example of how we use the data from our E.H.R to drive outcomes.
An analysis of our OBQI reports revealed that Congestive Heart Failure (CHF) was our number one hospitalization Diagnosis.

A decision was made to design and implement a Best Practice Protocol for Congestive Heart Failure clients with the ultimate goal of impacting on hospitalizations.
Congestive Heart Failure Example

Using a combination of our data in the OASIS and an evaluation of the electronic health record, we are able to establish more formalized tracking systems to analyze: hospitalizations, follow up education, and use of telehealth.
Congestive Heart Failure Best Practice

1. Each client will receive teaching materials on CHF. Patient/Caregiver response will be documented.
2. Clients will be encouraged to post “Congestive Heart Failure, When to Call your Nurse” on the refrigerator or where it can be readily available to client/caregiver.
3. Teaching and patient/caregiver understanding will be documented in the client record.
4. Clients will be instructed in how to obtain accurate weight and logging daily weights.
5. Clients will receive stat visit or increased visits when needed based on findings.
6. Client/caregiver will be observed using Telehealth and can state they understand how to use it.
JHL Outcomes Evaluation via EHR

JHL Congestive Heart Failure Related Hospitalization Rate

- YTD 2002
- YTD 2003
- YTD 2004
- YTD 2006
- YTD 2007 Q1-Q3

Benchmark
Telehealth

A “one to many” daily client monitoring system to improve self-care, promote early intervention, increase medication adherence and reduce overall costs.
Telehealth

Telehealth allows us to receive more information from our clients on a more regular and consistent basis.

This data is then inputted into our EHR and allows for more up to date and accurate assessments of how our clients are doing and who may be at risk and require additional intervention.
Best Practices Endeavors

So, our ability to gather data from the E.H.R. and telehealth units allows us to identify high risk disease/care areas for our clients.

This identification leads to development of an Evidenced Based Clinical Best Practice, which frequently includes some form of telehealth.

The impact and evaluation of these best practices are facilitated through our electronic health record which allows for us to easily create reports, and collect and analyze data to impact on client outcomes.
Example #2: Impact of Diabetes Best Practice with Telehealth

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<th>Control</th>
<th>Non-video Telehealth</th>
<th>Non-video Telehealth + Medication Dispenser</th>
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JHL received “Excellence in Home Health Quality Improvement Award” in 2004 and 2006 from IPRO for decreased hospitalizations.
Next Steps: Partnering

Our data systems now allows us to partner with other health care organizations to combine our technology efforts to impact larger patient populations and improve continuity of care.
Next Steps: Partnering

We are working with Mount Sinai Hospital’s RHIO on their HEAL 10 grant application. The concept here is that multiple providers will utilize technology to focus on provision of care to the diabetic population living in Central and East Harlem. These providers will link their technology so that each component of the care continuum (hospital, clinics, home care) has data access.
Next Steps: Partnering

We are also working with the New York City Department of Health and Mental Hygiene (DOHMH) Primary Care Information Project’s (PCIP) on their HEAL 10 grant application. In this proposal, Jewish Home Lifecare will facilitate the use of physician portals by community physicians and staff. Again, there will be data sharing across the continuum.

This critical information will be of great benefit to the community MDs in planning and coordinating the care of these diabetic patients, whose medical needs often span across primary care physicians, specialists, agencies and other health care settings.
Closing

Chronic Disease management and long term care will only continue to grow with our aging population.

It is imperative that organizations involved in long term care have the ability to collect, analyze and trend data both for internal benchmarking and connection with other components of the care continuum.

We hope that you found our sharing of the technology we are using to begin addressing this challenge helpful in your own planning efforts.