



Measuring Treatment Plans

Presented by: Kim Look





STANDARD OF CARE



Standard Operating Procedures



- **Consistency in Care:** Ensures uniform, standardized treatment across all providers.
- **Enhanced Patient Safety:** Reduces errors and mitigates risks.
- **Improved Efficiency:** Streamlines workflows and saves time.
- **Legal Protection:** Reduces liability by adhering to accepted practices.
- **Better Training:** Provides clear guidelines for staff onboarding and training.
- **Continuous Improvement:** Serves as a benchmark for quality control and adaptation.
- **Enhanced Communication:** Facilitates better teamwork and patient understanding.
- **Regulatory Compliance:** Helps meet standards and prepare for audits.



Top two concerns

1

How do I know what will work for patients?

2

How do I maintain credibility with my conventional colleagues?

Key benefits of standard of care?



Improved Patient Outcomes

- Consistency in care reduces variability in outcomes.
- Evidence-based practices lead to better health and recovery rates.

Enhanced Patient Safety

- Minimizes errors through established protocols.
- Mitigates risks with standardized procedures.

Key benefits of standard of care?



Increased Efficiency

- Streamlined processes save time and reduce costs.
- Eliminates unnecessary variations in treatment.

Legal Protection

- Shields providers from liability by following accepted practices.
- Sets clear expectations, crucial for defending against claims.

Better Communication

- Provides a common language among healthcare providers.
- Improves patient understanding of care plans.

Key benefits of standard of care?



Continuous Improvement

- Establishes benchmarks for quality and evolving practices.
- Adapts to new research and technologies.

Trust and Credibility

- Builds patient confidence in their care.
- Enhances professional credibility for healthcare providers.

Don't Throw the Baby Out with the Bath Water



Preserve the Good While Embracing Change

Acknowledge Existing Success:

- Recognize the value in current practices that have proven effective.
- Maintain successful elements of existing protocols.

Balance Innovation with Tradition:

- Embrace new methods and technologies without abandoning what works.
- Integrate new practices thoughtfully, ensuring they enhance rather than replace the core of what is effective.

Cautious Implementation:

- Evaluate new approaches carefully before full adoption.
- Ensure that changes do not inadvertently eliminate valuable aspects of patient care.



IV Evaluation Form



PATIENT EVALUATION FORM

PATIENT APPOINTMENT

Your health and wellness are of the utmost importance to us. To better understand how you are doing, and to better serve you, please fill out this form as best you can.

Today's Date: ____ / ____ / ____ Patient Name: _____
Last Name First Name

Checked-In By: _____

PATIENT'S CURRENT STATUS

On a scale of 1 to 10, how do you feel today? 1 2 3 4 5 6 7 8 9 10
(Horrible) (Great)

What percentage of improvement have you experienced since your last visit? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

In what areas are you showing improvement? _____

Do you have any questions we need to address?
 1.) _____

 2.) _____

 3.) _____

PATIENT'S CURRENT STATUS (CONT.)

Your Energy Level: 1 2 3 4 5
(Low) (High)

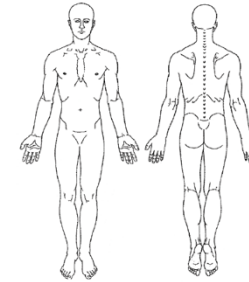
Your Sleep Quality: 1 2 3 4 5
(Low) (High)

Your Activity Level: 1 2 3 4 5
(Low) (High)

Your Digestion: 1 2 3 4 5
(Bad) (Good)

Your Mental Attitude: 1 2 3 4 5
(Poor) (Great)

Please indicate below your areas of concern or pain, and rate them in order of priority (1, 2, 3).



IN-OFFICE USE ONLY

Physician's Notes: _____

Today's Treatment Plan

TREATMENT	TREATMENT NOTES	COMPLETED	STAFF INITIALS
1.) _____	_____	<input type="checkbox"/>	_____
2.) _____	_____	<input type="checkbox"/>	_____
3.) _____	_____	<input type="checkbox"/>	_____
4.) _____	_____	<input type="checkbox"/>	_____
5.) _____	_____	<input type="checkbox"/>	_____
6.) _____	_____	<input type="checkbox"/>	_____

Office Notes: _____

Patient Evaluation



PATIENT EVALUATION FORM

PATIENT APPOINTMENT

Your health and wellness are of the utmost importance to us. To better understand how you are doing, and to better serve you, please fill out this form as best you can.

Today's Date: ___/___/___ Patient Name: _____
Last Name First Name

Checked-In By: _____

CURRENT STATUS

On a scale of 1 to 10, how do you feel today? 1 2 3 4 5 6 7 8 9 10
Terrible Great

What percentage of improvement have you experienced since your last visit?
 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

In what areas are you showing improvement? _____

Do you have any questions we need to address?

1.) _____

2.) _____

3.) _____

Your Energy Level: 1 2 3 4 5
Low High

Your Sleep Quality: 1 2 3 4 5
Low High

Your Activity Level: 1 2 3 4 5
Low High

Your Digestion: 1 2 3 4 5
Bad Good

Your Mental Attitude: 1 2 3 4 5
Poor Great

Please indicate below your areas of concern of pain and rate them in order of priority (1,2, and 3).

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On a scale of 1 to 10, how do you feel today? 1 2 3 4 5 6 7 8 9 10
Terrible Great

What percentage of improvement have you experienced since your last visit?
 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Do you have any questions we need to address?

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Your Energy Level: 1 2 3 4 5
Low High

Your Sleep Quality: 1 2 3 4 5
Low High

Your Activity Level: 1 2 3 4 5
Low High

Your Digestion: 1 2 3 4 5
Bad Good

Your Mental Attitude: 1 2 3 4 5
Poor Great

Please indicate below your areas of concern of pain and rate them in order of priority (1,2, and 3).

Patient Evaluation



CURRENT STATUS

List your top five main complaints in order from worst to least, and rate their severity.

1.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

2.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

3.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

4.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

5.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

IN-OFFICE USE ONLY

Vitals Before Tx:

Blood Pressure: _____ / _____ Heart Rate: _____ bpm Oxygen: _____ bpm

Vitals After Tx:

Blood Pressure: _____ / _____ Heart Rate: _____ bpm Oxygen: _____ bpm

Physician's Notes: _____

Today's Treatment Plan			
TREATMENT	TREATMENT NOTES	COMPLETED	STAFF INITIALS
1.) _____	_____	<input type="checkbox"/>	_____
2.) _____	_____	<input type="checkbox"/>	_____
3.) _____	_____	<input type="checkbox"/>	_____
4.) _____	_____	<input type="checkbox"/>	_____
5.) _____	_____	<input type="checkbox"/>	_____

Office Notes: _____

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CURRENT STATUS

List your top five main complaints in order from worst to least, and rate their severity.

1.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

2.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

3.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

4.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

5.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible Great

IN-OFFICE USE ONLY

Vitals Before Tx:

Blood Pressure: _____ / _____ Heart Rate: _____ bpm Oxygen: _____ bpm

Vitals After Tx:

Blood Pressure: _____ / _____ Heart Rate: _____ bpm Oxygen: _____ bpm

Physician's Notes: _____

Patient Evaluation



CURRENT STATUS

List your top five main complaints in order from worst to least, and rate their severity.

1.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible → Great

2.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible → Great

3.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible → Great

4.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible → Great

5.) _____ 1 2 3 4 5 6 7 8 9 10
Terrible → Great

IN-OFFICE USE ONLY

Vitals Before Tx:

Blood Pressure: _____ / _____ Heart Rate: _____ bpm Oxygen: _____ bpm

Vitals After Tx:

Blood Pressure: _____ / _____ Heart Rate: _____ bpm Oxygen: _____ bpm

Physician's Notes: _____

Today's Treatment Plan

TREATMENT	TREATMENT NOTES	COMPLETED	STAFF INITIALS
1.) _____	_____	<input type="checkbox"/>	_____
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3.) _____	_____	<input type="checkbox"/>	_____
4.) _____	_____	<input type="checkbox"/>	_____
5.) _____	_____	<input type="checkbox"/>	_____

Office Notes: _____

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Today's Treatment Plan

TREATMENT	TREATMENT NOTES	COMPLETED	STAFF INITIALS
1.) _____	_____	<input type="checkbox"/>	_____
2.) _____	_____	<input type="checkbox"/>	_____
3.) _____	_____	<input type="checkbox"/>	_____
4.) _____	_____	<input type="checkbox"/>	_____
5.) _____	_____	<input type="checkbox"/>	_____

Office Notes: _____

Vitals Before: Vitals After: Patient ate prior:

Tx 1: MAH/UBI 60:60 60 gamma - followed SOP

Tx 2: 250ml Normal Saline

Tx 3: Myers 1 – Lot # and Rx #

Start time: 2:00p Stop Time: 5:15p

Notes: RAC x1 attempt w/ 22G catheter. Good blood return noted. Patient tolerated well. Catheter removed and pressure applied. Patient left in stable condition w/spouse.

What Does PE Form Do for Office?



- Communicates to office and provider
- HIPPA compliant IV room
- SOAP (charting) w/ efficiency
- Accurately and efficiently gathers data for ROF consult
- Allows for tweaking
- **Internal** tracking/communication
- Builds testimonial/ clinical outcome material
- Builds BELIEVERS

What Does PE Form Do for Patients?



- Communicates to office and provider
- HIPPA compliant IV room
- Journaling
- Awareness
- *Perceived Value*
 - Enhanced *perceived* likelihood of achievement
 - Shows quick emotional and physical wins – ‘experience victories early on’
 - Diminishes need to “download” all the details at ROF consult
 - Builds “belief” in patients (and staff)

What Does PE Form Do for the Industry?



- Protects the Medicine
- Builds Evidence-Based Medicine
- Supports Standard of Care
- Establishes and grows safety and efficacy data
- Leaves a Legacy

Clinical Trial Candidate Search



Goal: Test data collection process for future app build

Goal: Enlist providers who share interest in collecting data to support IV therapy

- Complete at least 5 Ivs/day
- Offer at least 3 IV formulas
- Use O3UV
- Dedicated IV staff
- Lab draw pre/post
- Each patient, each IV

- 30-day commitment
- Agree to onboarding process
- Agree to provide feedback
- Agree to follow tx plans

We Provide:

- Intro Video to onboard patients
- iPad preloaded with videos/links
- Preloaded treatment plans
- Interactive Patient Evaluation form for easy pt use and compliance.