Speaker

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Leveraging Mobile Care Coordination Technology to Improve Care Transitions

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Supported in part by
GORDON AND BETTY MOORE FOUNDATION
Our Approach

1. Team-based
   Patient-centered multidisciplinary care teams

2. End-to-End
   Both inpatient and post-discharge

3. Collaborative
   Work with surrounding area providers

4. Technology Assist
   Connect everyone taking care of a patient
Our Approach

- **Project RED®**
  For ALL patients

- **Care Transitions Intervention®**
  High risk patients 65+

- **Carebook™**
  Real-Time Mobile Care Team Collaboration
A Multidisciplinary Approach

Project RED® + CTI® + Carebook™

Admit ➔ Hospital Stay ➔ Discharge ➔ Post-Discharge

- Set est. Date of Discharge & Disposition
  - Team
  - MD, MRT
  - Reconcile Meds
  - Assess Discharge Barriers & Risks
  - Notify team of Discharge in 24
  - Reconcile Meds
  - Follow-up Appointments
  - Hospital Visit
  - High
  - Patient Risk
  - Complete all patient risk-specific interventions. Engage patient & caregiver using Teach-back
  - RN
  - Team
  - MD
  - Home Visit
  - Follow-up Calls

- Coac
  - Follow-up Calls

- Sup. RN
  - Rest

Project RED® and CTI® are registered trademarks of Boston University Medical Center and The Care Transitions Program of the UC, Denver.
Community Partnering for Transitions

Nation’s FIRST Mobile Care Transitions Network™
Technology Needs for Patient-Centered Collaborative Care

- **Dynamic & Complete** Care Team
- **Efficient, Fast** Team Communication
- **Collaborative** Assessment & Planning
- **Shared Dynamic** Checklists
- **Real-Time** Push Notifications
- **Make it Easier**
Carebook™
Real-time Mobile Care Coordination Platform

Assess & Plan
Coordinate
Follow-up & Monitor

Inpatient Care Team

Low Risk
High Risk

Please confirm that you have your medications

Aftercare Providers (Clinic, Coaches, Care Managers etc.)
Carebook Concepts I
Shared, Dynamic Checklists with Real-Time Notifications*

Payne, Hart

2+ Hospitalizations in 6 months
Substance Abuse
Cognitive Impairment
Limited or No Insurance
Limited Social Support
Limited Transportation
No PCP
Failed Teach-back

Patient Hart Payne
Est. Discharge on 9/5/13
Identify support resources

Social Worker

Patient Hart Payne
Est. Discharge on 9/5/13
Check coaching eligibility

Coach Coordinator

*Patent Pending
Carebook Concepts II
Care Team Collaboration*

Instantly identify care team
See who is on/offline
Select one or more for messaging

Reach care team members
Know when they read your message
Get instant response

*Patent Pending
Mobile Technology Deployment

Hospital purchased devices for staff
iPads for Case Managers, Social Workers, Coaches
iPodTouches for others – Nurses, Ancillary staff…

Physicians used personal iPhones (BYOD)
Coaches used iPads with keyboards
Secure charging docks at Nursing Stations
See-through Cases & Screen covers
Mobile device usage policy drafted

Nation’s FIRST Mobile Care Transitions Network™
1. Multidisciplinary root-cause analysis
   Identify opportunities & interventions for improvement
2. Multidisciplinary build team for “designing” the tool
   Make it theirs
3. Training across the organization
   Hands-on, Videos, Posters, Pocket guides, Trainer walk-the-halls
4. Pilot Unit Deployment
   Start with a small unit and subset of roles
5. Go-Live
   It’s a big deal. Make it exciting
INTRODUCING COAST®MARIN

COLLABORATIVE FOR OLDER ADULTS SAFE TRANSITIONS

COAST®Marin is a program to help older adults to safely navigate through transitions from care at the hospital to their homes or aftercare providers.

Key Components

PROJECT RED®
A program that educates patients 65 and older about their diagnosis and care during their hospital stay and prepares them for a safe and smooth discharge.

CARE TRANSITIONS & INTERVENTION®
A collaborative program that provides select older adults with a community agency coach to assist in a successful transition after hospitalization.

CAREBOOK
A HIPAA-compliant mobile tool accessible via the web or mobile device (iPad, iPhone, etc.) that enables all members of a care team to connect and coordinate seamless patient care, both in and out of the hospital.

COAST®Marin will launch in the coming months.

Watch for details in MGH Connections e-Newsletter or for more information, email Teri Winter, director of the program: wintert@maringeneral.org.

RED ALERT: #3 in a series of valuable updates about project RED

Applying Project RED with our new CAREBOOK app

Now that you’ve learned about Project RED, you are probably wondering how we plan to implement these changes in our education and discharge process. Well, like so many things we do these days, there’s an app for that! Marin General Hospital (MGH) is the first hospital to adopt a groundbreaking web-based mobile collaboration tool called CAREBOOK, from CareInSync™.

CAREBOOK is real-time, collaborative software designed to improve the three C’s of patient care: Collaboration, Coordination, and Communication. The app has been customized for MGH and links all the members of a patient’s care team—doctors, nurses, physical and occupational therapists, social workers, and potentially, even the patient’s PCP or referring specialist. In order to connect to CAREBOOK, team members will receive an iPad or iPod touch, while physicians will modify their iPhones. Information on each individual screen will be personalized to the user’s needs and tasks.

RED ALERT: #4 in a series – COAST®Marin companion program to Project RED

Making discharge safer for patients over 65

Project RED is intended to make the discharge process safer and more effective for all our patients. But for the most vulnerable patients, Project RED may not be enough. Over half of Marin General Hospital discharges are patients aged 65 or older. In 2013, 11.4 percent of patients in this age group were readmitted within 30 days, and 23.4 percent were readmitted within 90 days. While these numbers are better than the national average, they can definitely be improved upon.

The challenges of caring for the elderly

A case review of our elderly discharges revealed that 75 percent couldn’t verbalize critical information...
Results
Team Coordination Increased

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
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</thead>
<tbody>
<tr>
<td># Mgs/Pt sent by Case Managers</td>
<td>2.7</td>
<td>3.3</td>
<td>4.4</td>
<td>4.4</td>
<td>4.8</td>
</tr>
<tr>
<td># Mgs/Pt sent by Nurses</td>
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<td>3.8</td>
<td>5.0</td>
<td>5.7</td>
<td>5.6</td>
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<tr>
<td># Mgs/Pt sent by Physicians</td>
<td>8.0</td>
<td>2.9</td>
<td>3.6</td>
<td>3.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Total # Mgs/Pt sent by Phy/Nurses/CaseManagers</td>
<td>13.0</td>
<td>13.7</td>
<td>13.4</td>
<td>13.4</td>
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Better Communications in Less Time

80% communications were in patient context

65% reduction in pages
## Efficient Care Delivery

<table>
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<tr>
<th>Staff Surveys</th>
<th>Before Carebook</th>
<th>After Carebook</th>
</tr>
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<tbody>
<tr>
<td>“I can easily determine the names of all care team members for my patients”</td>
<td>32%</td>
<td>69%</td>
</tr>
<tr>
<td>“I can easily or efficiently contact all members of my patient’s care Team to notify them about changes to the discharge plans” (MDs)</td>
<td>8%</td>
<td>72%</td>
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</table>

% of staff who chose “agree” or “strongly agree”
“Did you get info in writing about what symptoms or health problems to look out for when you left the hospital?”
Improved Patient Discharge Experience

“Did hospital staff talk to you about whether you would have the help you needed when you left the hospital?”
Connecting Patients & Providers

One-touch electronic referral to safety-net clinic (Marin Community Clinic)
More appointments being scheduled prior to discharge
More Coaching Referrals

No. of Patients Referred to CTI per month

<table>
<thead>
<tr>
<th># Patients</th>
<th>Before Carebook</th>
<th>After Carebook</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80</td>
<td>112</td>
</tr>
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</table>

40% increase in patients referred with Carebook
Medication Discrepancies Intercepted

13% of coached patients had a medication discrepancy discovered.

Assessed for Coaching Eligibility

Doe, John
High Risk
30-Day Readmissions Trending Down

Month-to-Month Run Chart

Patient Age > 64yrs
Reduction in ALOS

Avg LOS -- Age 65 and older

Planning

Go-Live

+3 sigma

-3 sigma

Jun 25, 2013 12:46:36
“I love being able to instantly communicate patient’s discharge plan to rest of the team and not chase one person at a time…about incomplete issues such as discharge MAR, transportation…”

- S. Reid – RN Case Manager

“Carebook has improved communication…and access to patient information crucial for setting up post-discharge follow-up appointment... We are able to do so for a lot more patients now.”

- Thomas Young, Community Clinic NP

“I visited a patient at home for transition coaching the day after she was discharged… We are able to identify the high risk patients with Carebook and coach them on how to manage the transition to home from the hospital“

- D. Hiser – Transition Coach

“I am a 50 year old nurse doing this for several decades and I am a technophobe. But, now that I have started using Carebook, I don’t know how I will do without it.”

- Nurse
What have we learned?
The Challenges

Get IT involved from the start
Go for phased implementations
Ensure enough “clearance” with other projects
Ensure policy support before house-wide launch
What have we learned?
The Gems

Multidisciplinary approach eased adoption
“*We built it together*”

Ancillary clinical staff loved it (speech, RT, PT etc.)

Viral adoption of communication due to efficiency
“*I want to be on Carebook*”

Carebook: a dynamic PI tool for front-line innovation

Rapid PDSA cycles with real-time performance tracking

Safer & **Efficient** care transitions
Acknowledgements

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Marin General Hospital Foundation

Marin Community Foundation

ARC Group