Speaker

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Leveraging Mobile Care Coordination Technology to Improve Care Transitions

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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

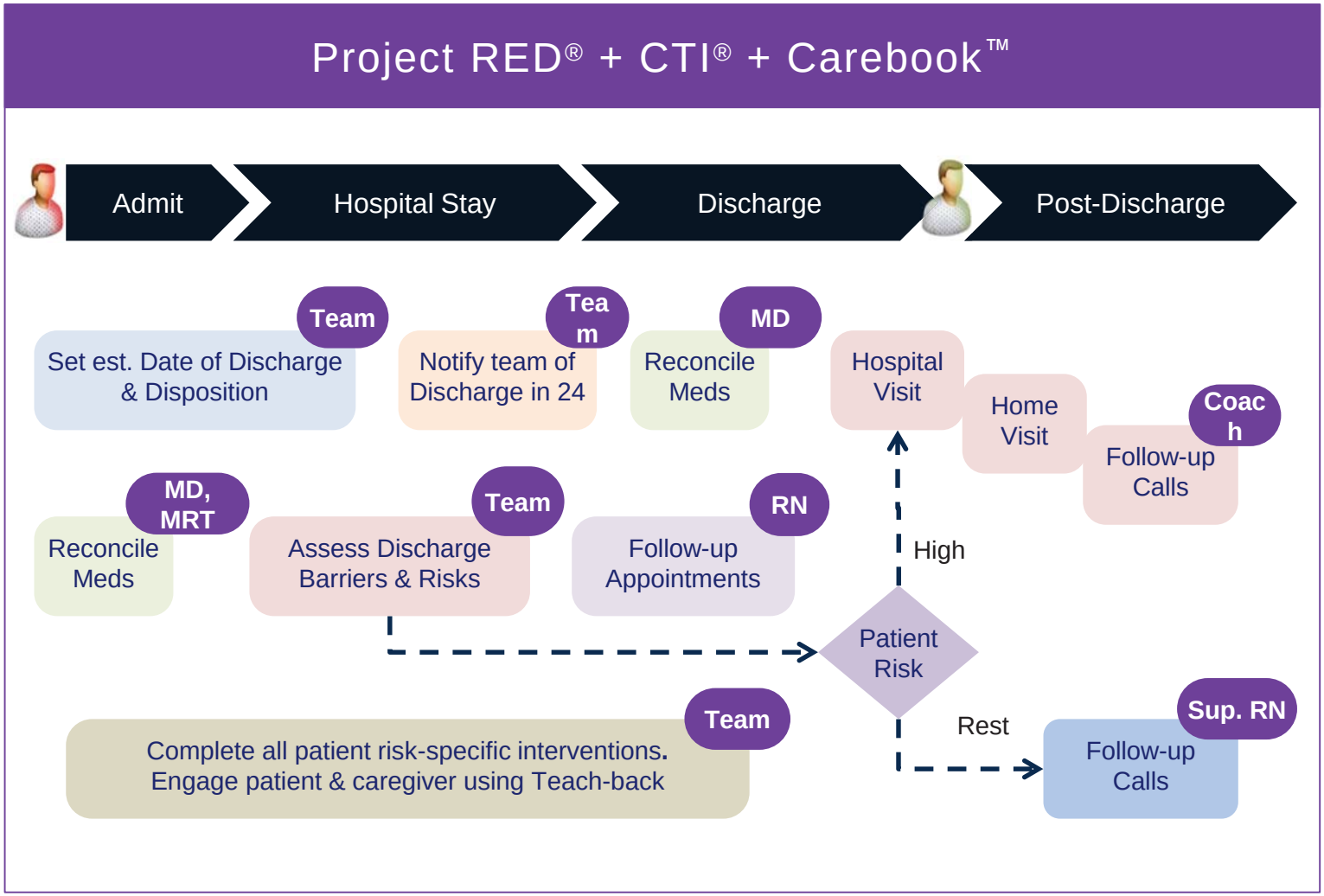
4. Technology Assist

   Connect everyone taking care of a patient

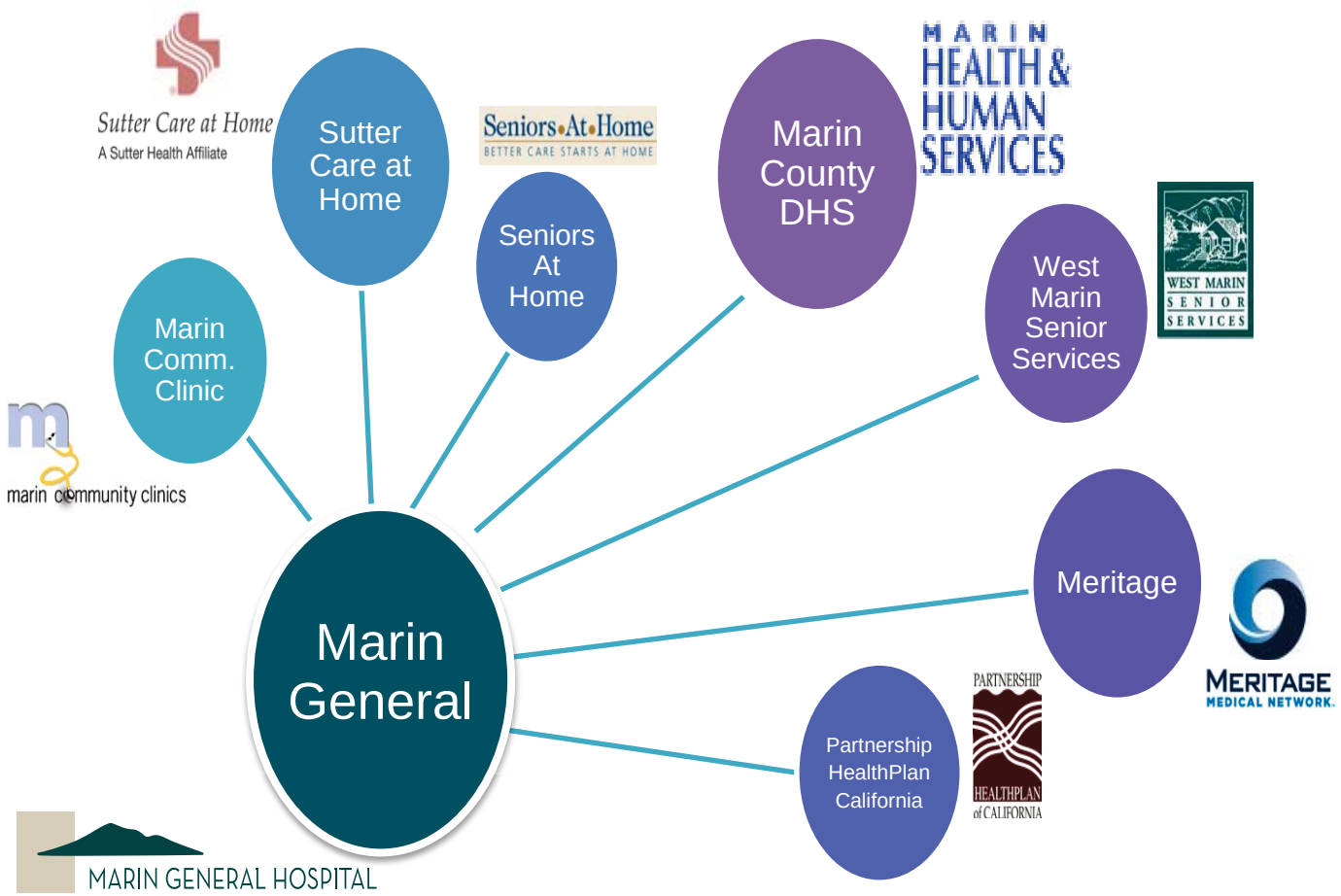
Our Approach

- Project RED®
  For ALL patients
- Care Transitions Intervention®
  High risk patients 65+
- Carebook™
  Real-Time Mobile Care Team Collaboration

A Multidisciplinary Approach

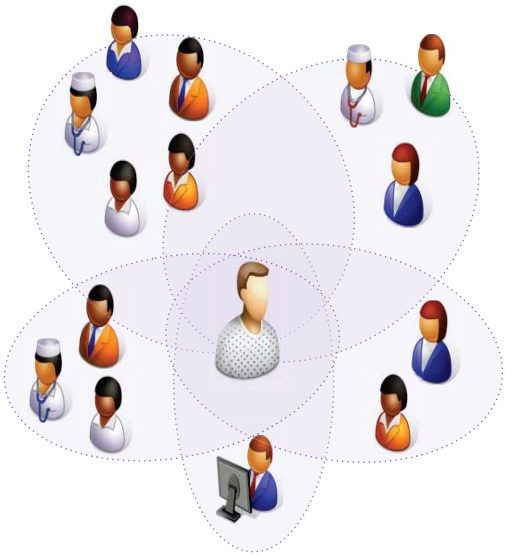


Community Partnering for Transitions



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

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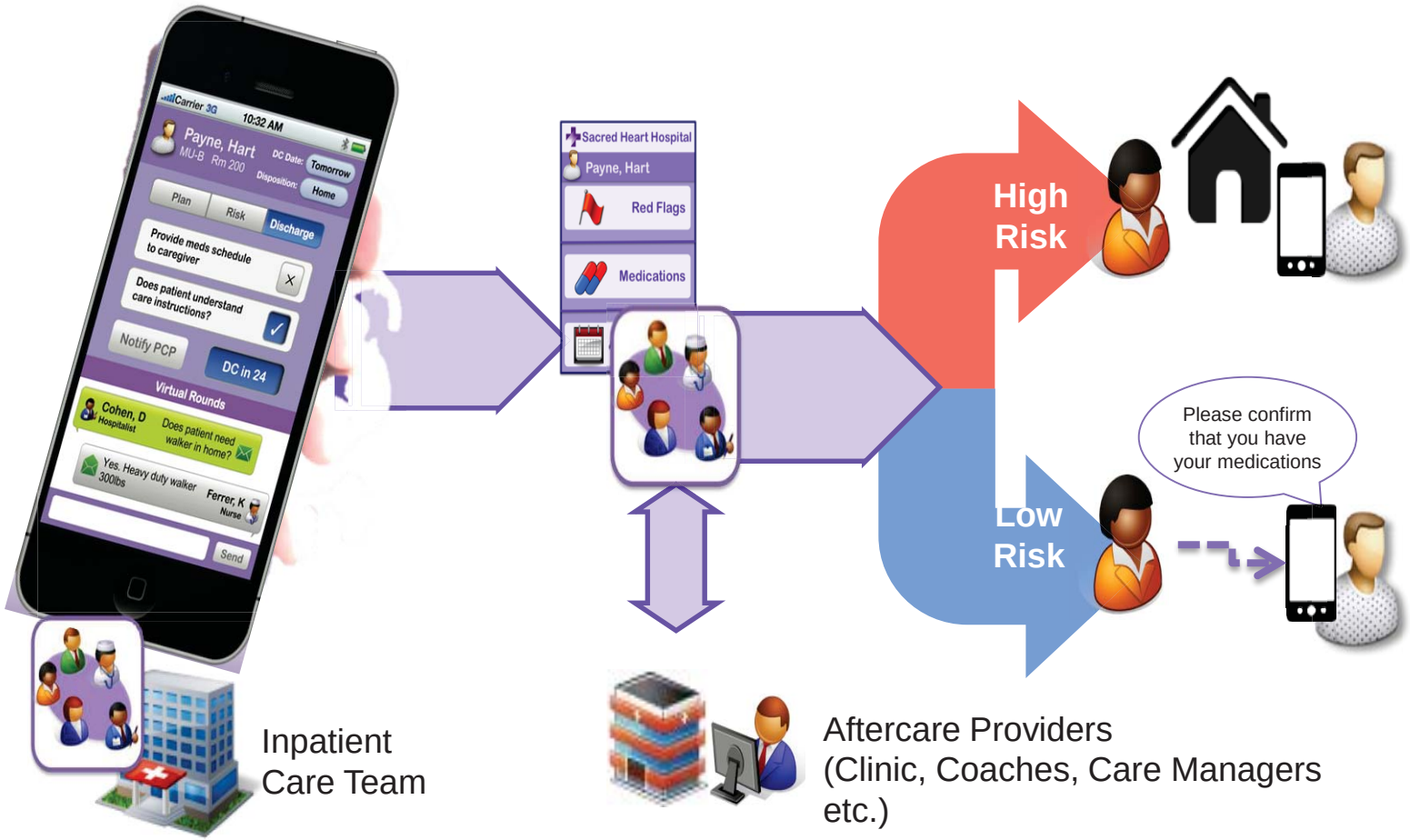
Assess & Plan

Coordinate

Follow-up & Monitor

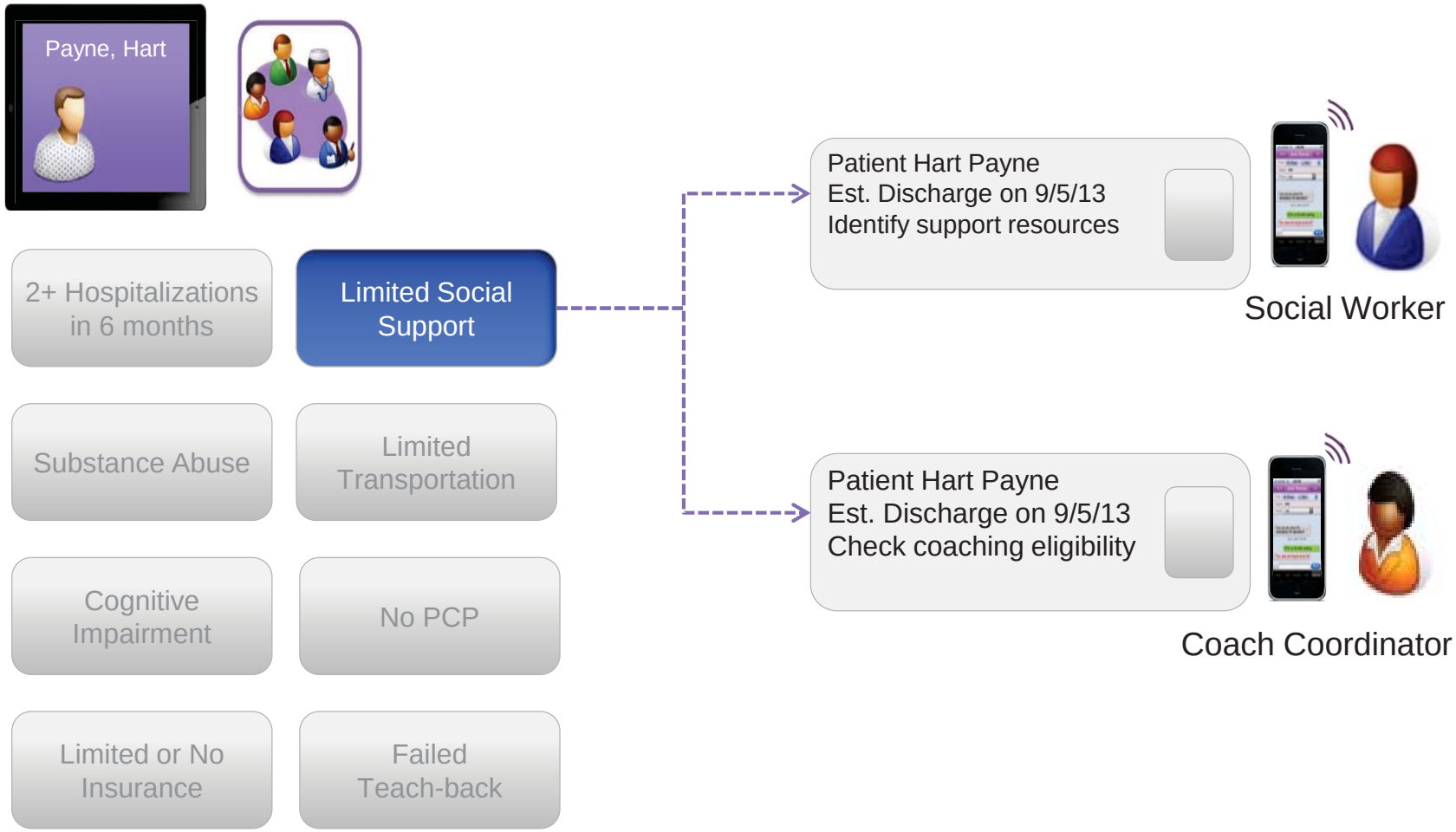


Inpatient Care Team

Aftercare Providers (Clinic, Coaches, Care Managers etc.)

Carebook Concepts I

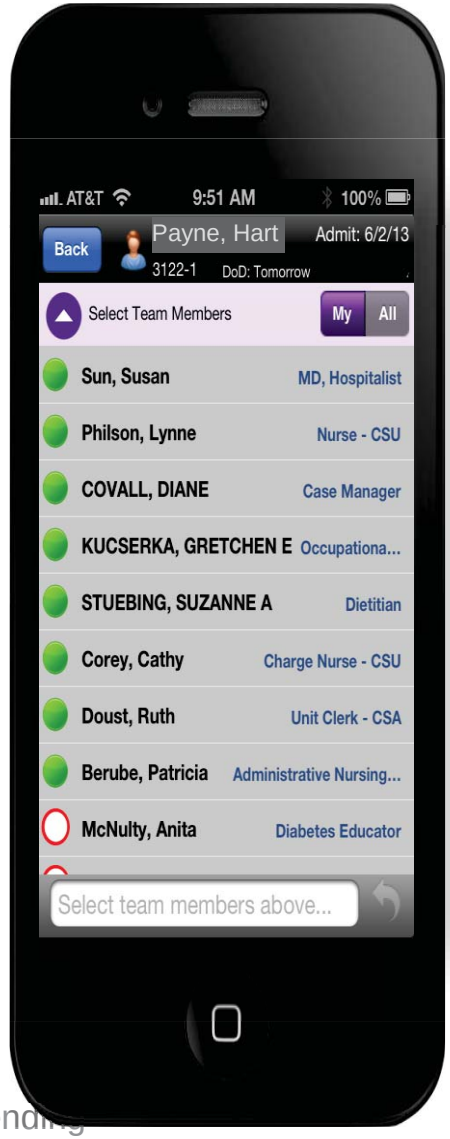
Shared, Dynamic Checklists with Real-Time Notifications*



*Patent Pending

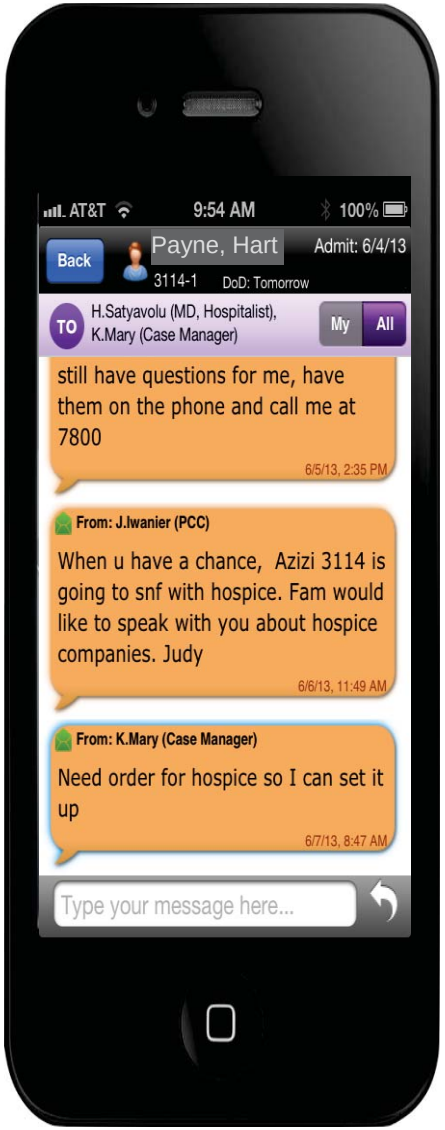
Carebook Concepts II

Care Team Collaboration*



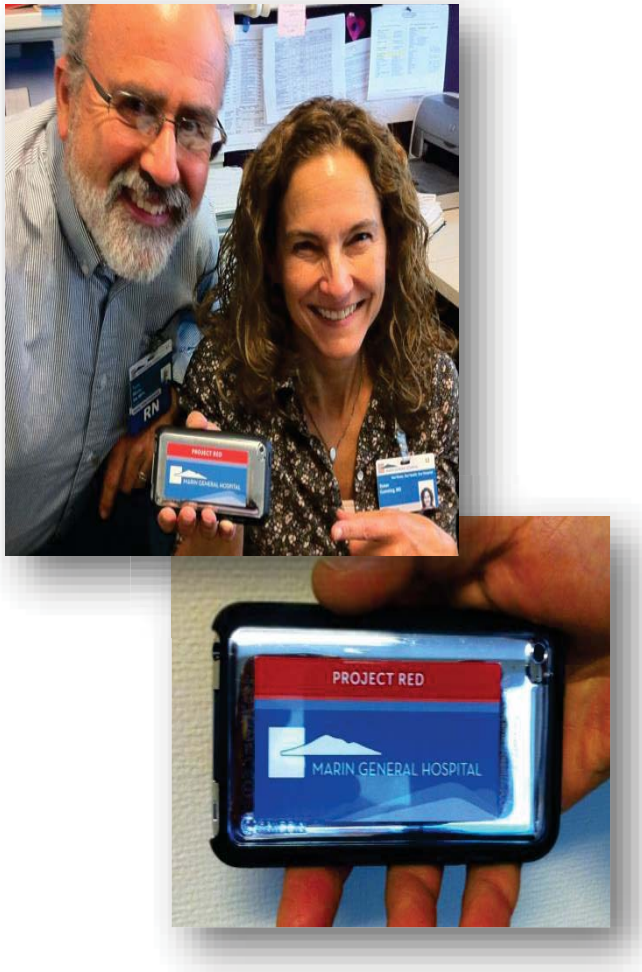
Instantly identify care team
See who is on/offline
Select one or more for messaging

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™

Implementation Phases

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

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COAST@Marin Program Goals

Improve care transitions

Enhance patient safety, quality of care and experence

Reduce avoidable readmissions and unnecessary ED visitors

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

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OUR HOME. OUR HEALTH. OUR HOSPITAL.

COAST@Marin will launch in the coming months.

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

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MGH CONNECTIONS
Employee Newsletter

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 mostly use their iPhones. Information on each individual screen will be personalized to the user's needs and tasks.

CONNECTIONS
oyee Newsletter

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

Making discharge safer for patients over 65

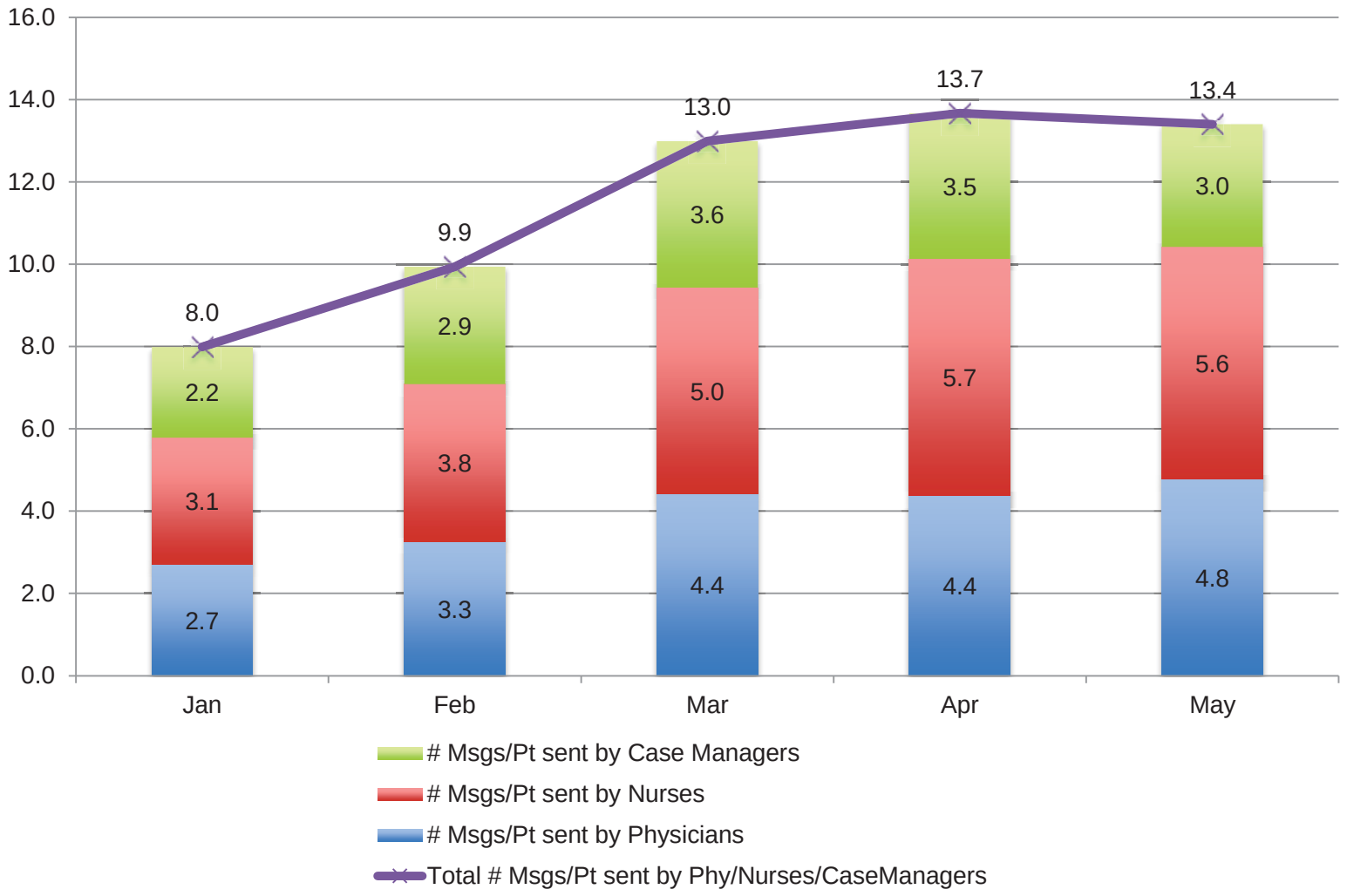
Project RED is intended to make the discharge process safer and more effective for all our patients. But for the most vulnerable patients, Project RED may not be enough. Over half of Marin General Hospital discharges are patients aged 65 or older. In 2010, 11.4 percent of patients in this age group were 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

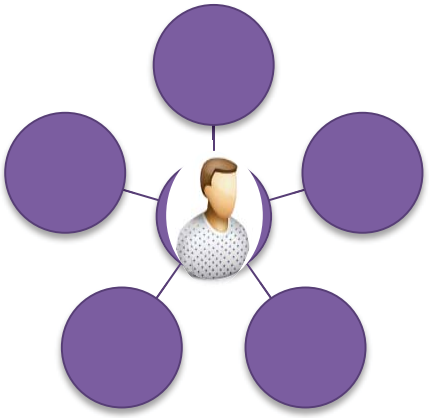
A case review of our elderly discharges revealed that 75 percent couldn't verbalize critical information

Results

Team Coordination Increased



Better Communications in Less Time



80% communications were in patient context

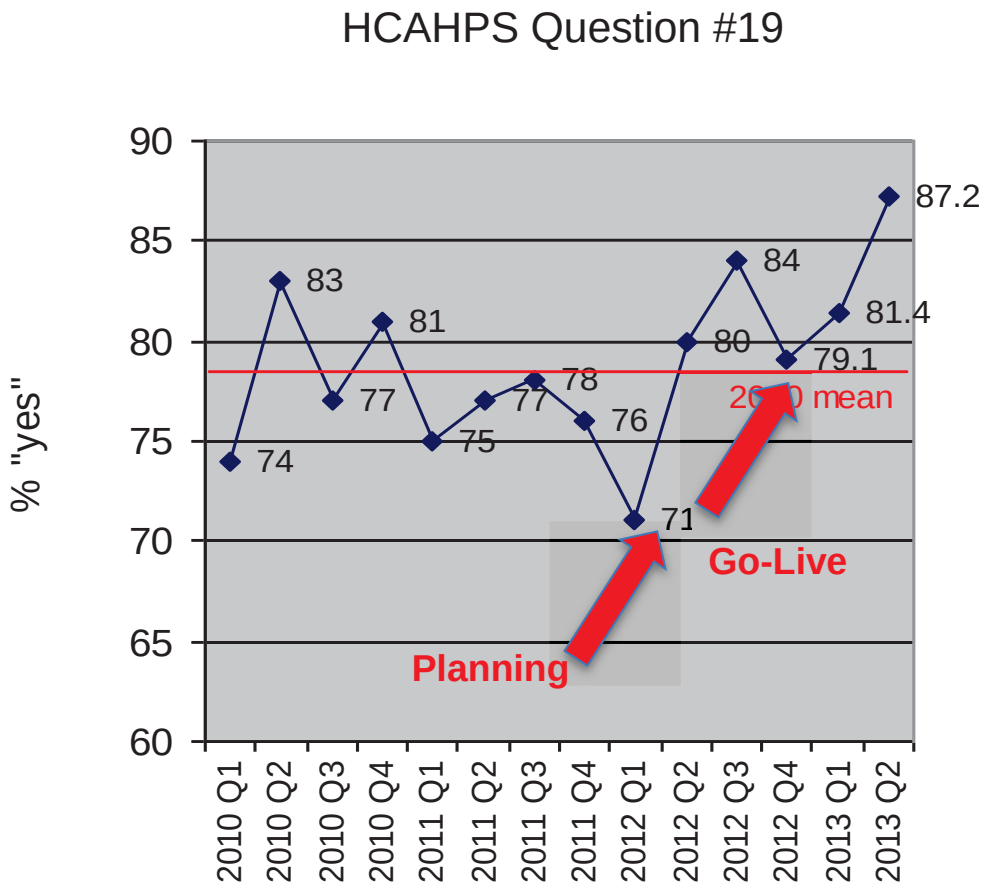
65% reduction in pages

Efficient Care Delivery

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

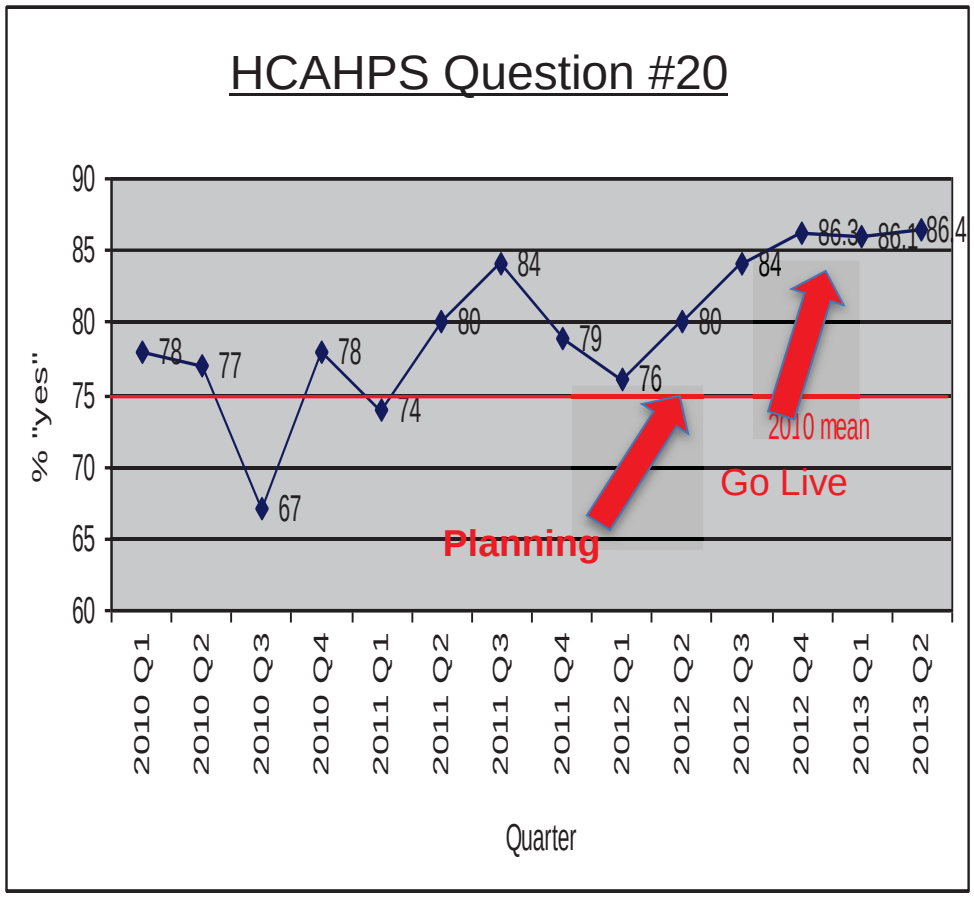
% of staff who chose “agree” or “strongly agree”

Improved Patient Discharge Experience



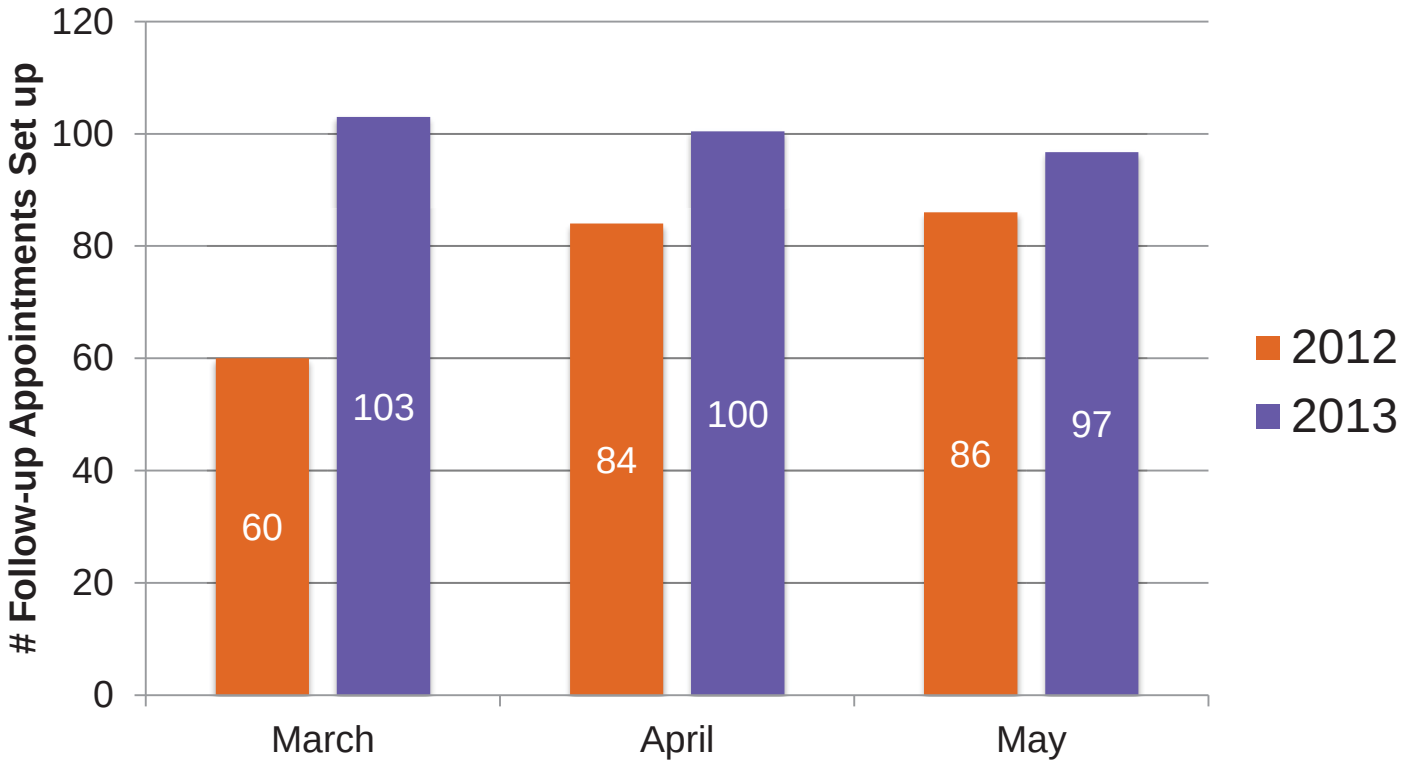
"Did you get info in writing about what symptoms or health problems to look out for when you left the hospital?"

Improved Patient Discharge Experience



"Did hospital staff talk to you about whether you would have the help you needed when you left the hospital?"

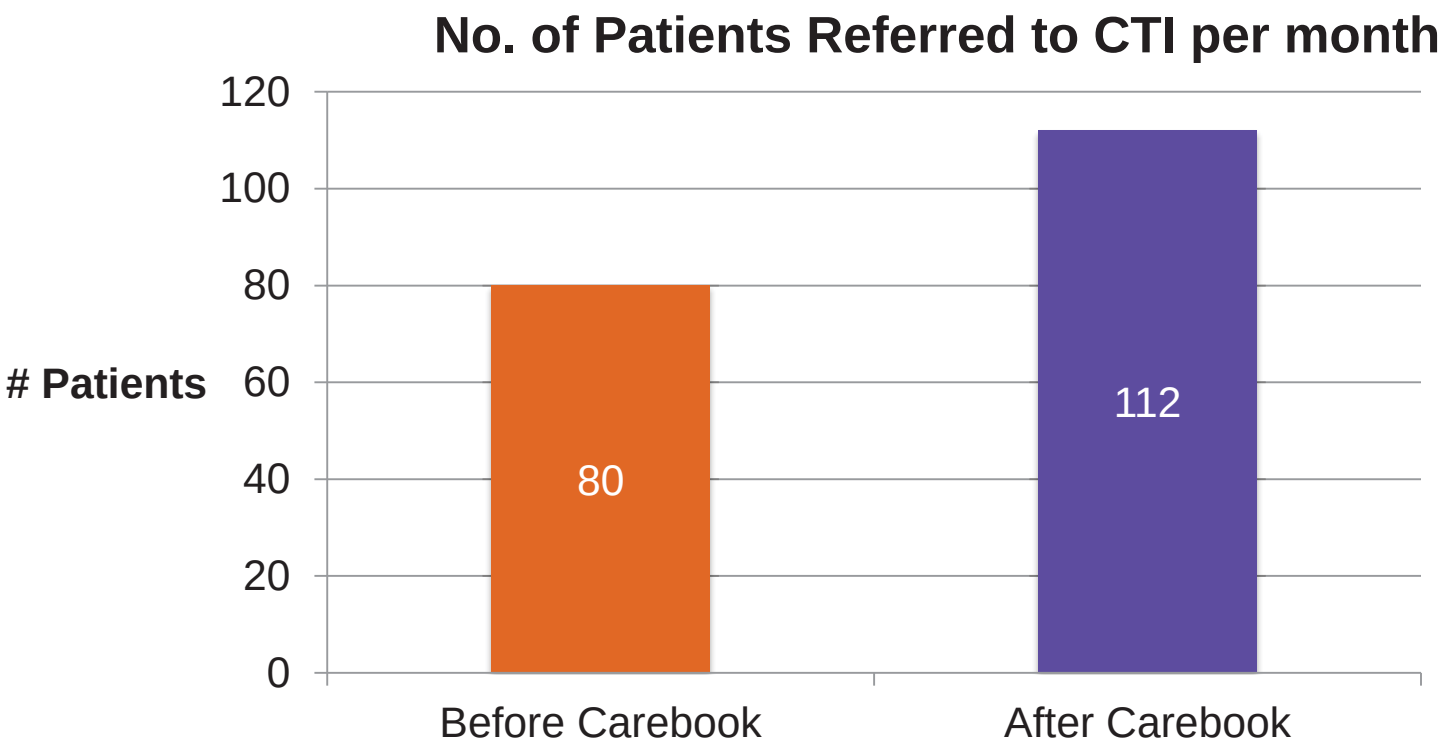
Connecting Patients & Providers



One-touch electronic referral to safety-net clinic (Marin Community Clinic)

More appointments being scheduled prior to discharge

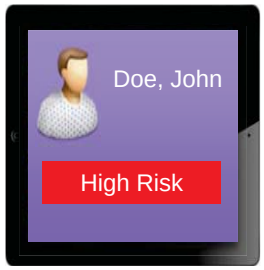
More Coaching Referrals



40% increase in patients referred with Carebook

Medication Discrepancies Intercepted

13%



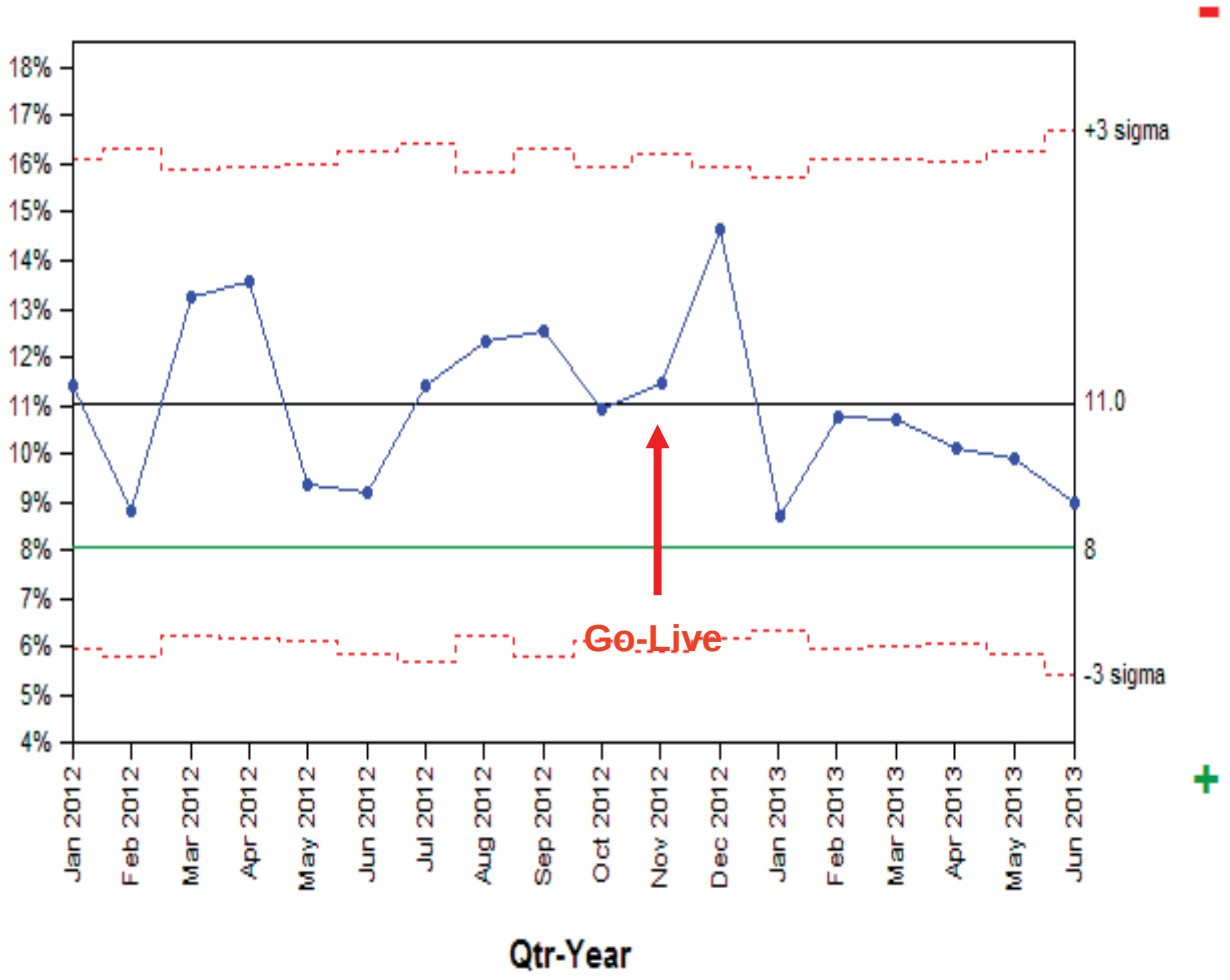
Assessed for Coaching Eligibility

39%

of coached patients had a medication discrepancy discovered

30-Day Readmissions Trending Down

Month-to-Month Run Chart



Patient Age > 64yrs

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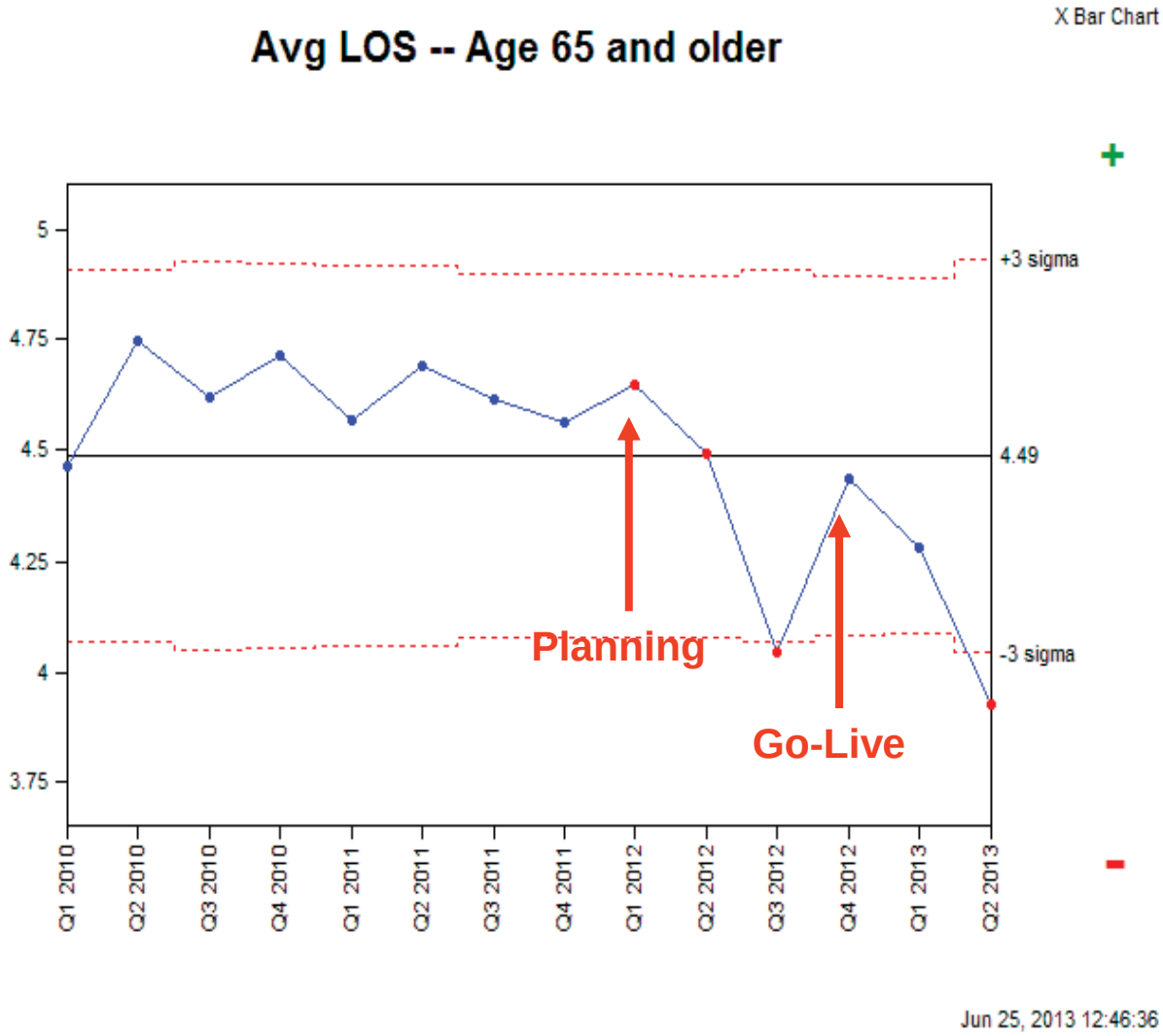
Reduction in ALOS



Staff Feedback

"**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

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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

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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

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