careinsync™

Lower Readmissions

Improve Patient Satisfaction

Reduce Length of Stay

Improve Staff Satisfaction

Better Care.

Lower Cost.

December 4, 2013

Leveraging Mobile Care Coordination Technology to Improve Care Transitions

Dec 2013

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The Problem

A patient admitted to a hospital will experience:

20-40 Care Providers
No "team" - Silos of Care
1-in-10 Chance of Harm[1]
1-in-5 Chance of Readmission[2]
Communication Failures Drive 70-80% Errors[3]

Cost to the Nation: $25B - $45B Annually[4]

[1] Agency for Healthcare Research and Quality, 2002.
[2] The Revolving Door, Robert Wood Johnson Foundation, 2013.
[3] Joint Commission Study 2006.
[4] Health Affairs – Policy Brief, Robert Wood Johnson Foundation, 2012.

Why is this challenging?

Care must be
evidence-based and *patient-centered…*

coordinated and *timely…*

But the care team is diverse, constantly changing, and on-the-go!

Our Approach

1. Connect Entire Team on Mobile devices
   Patient-centered multidisciplinary care teams

2. End-to-End Evidence-based[1,2]
   Proven inpatient, post-discharge & "BYO" interventions

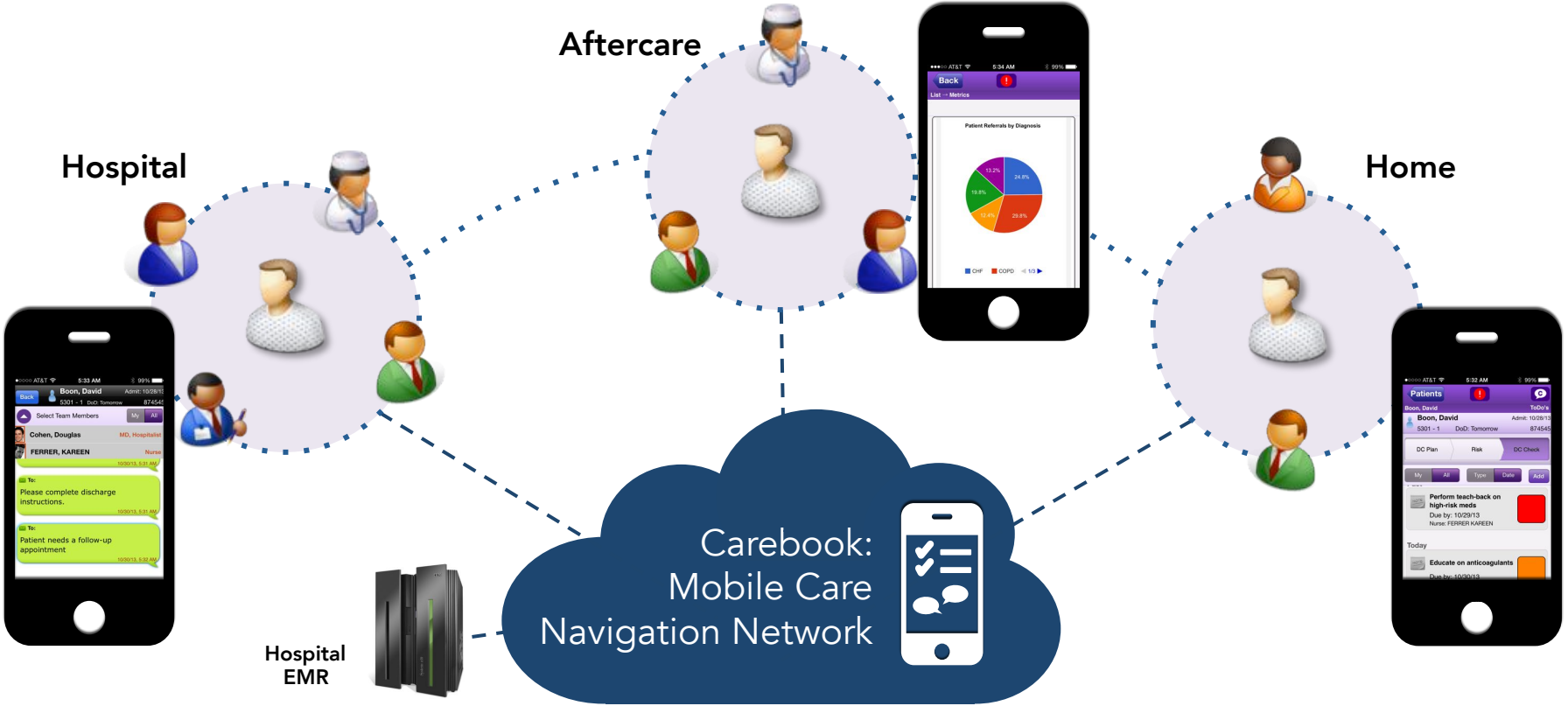
3. Collaborative Model
   Work with surrounding area care providers

[1] Project RED - Re-Engineering Discharge, Boston University Medical Center.

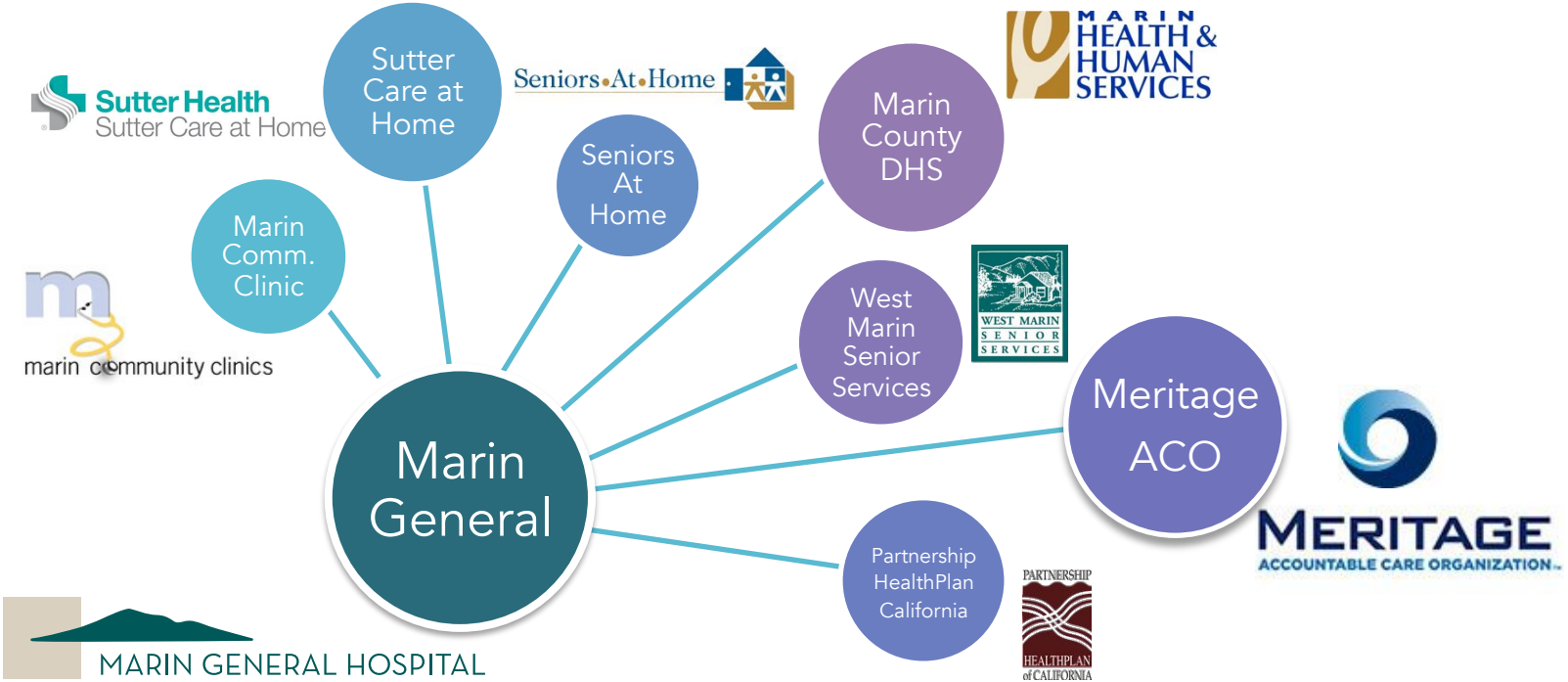
[2] Project BOOST – Better Outcomes for Older adult Safer Transitions, Society of Hospital Medicine.

Carebook: The GPS for Care Teams™

Collaborative, Patient-centered, Evidence-based

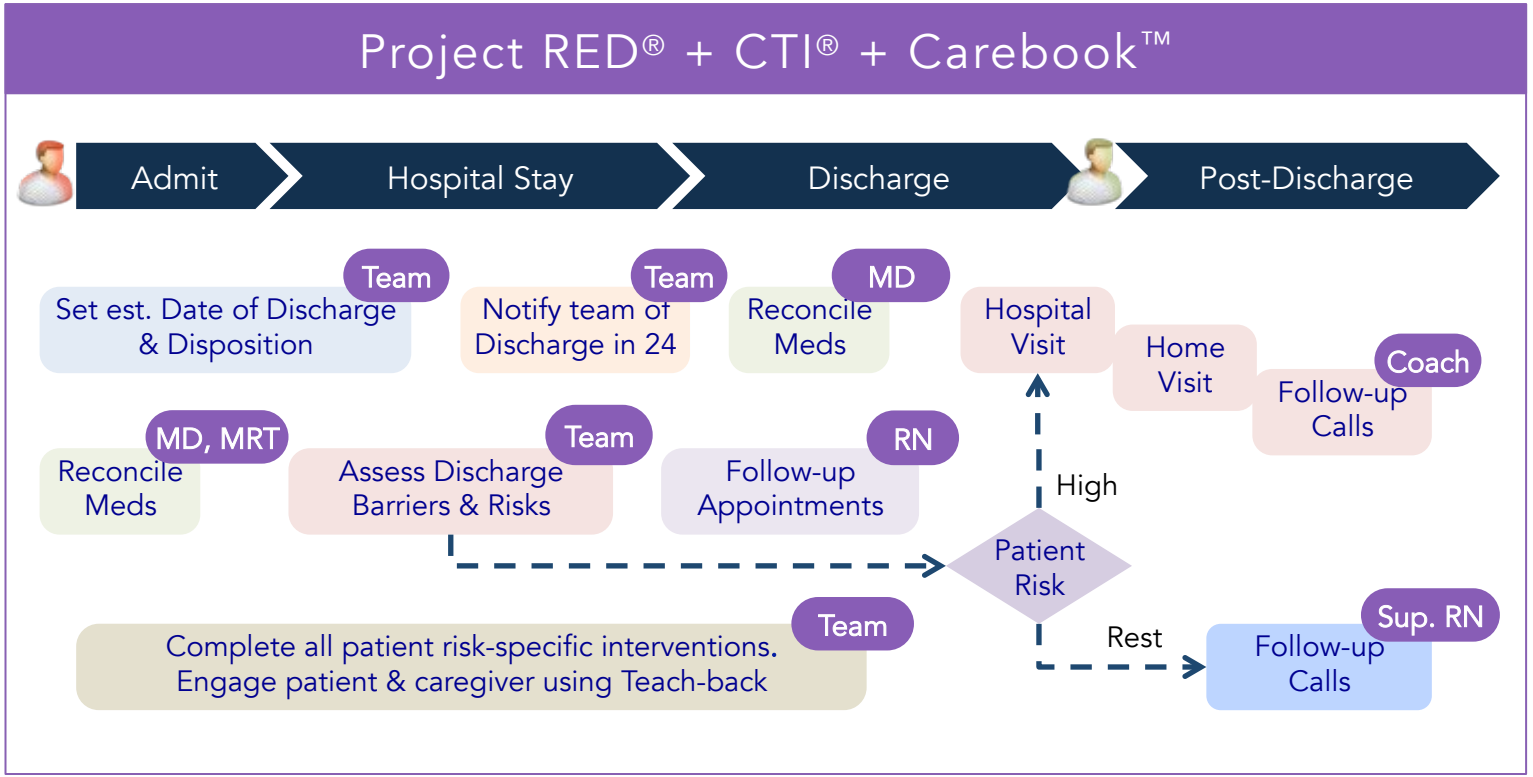


Collaborative Model for Transitions

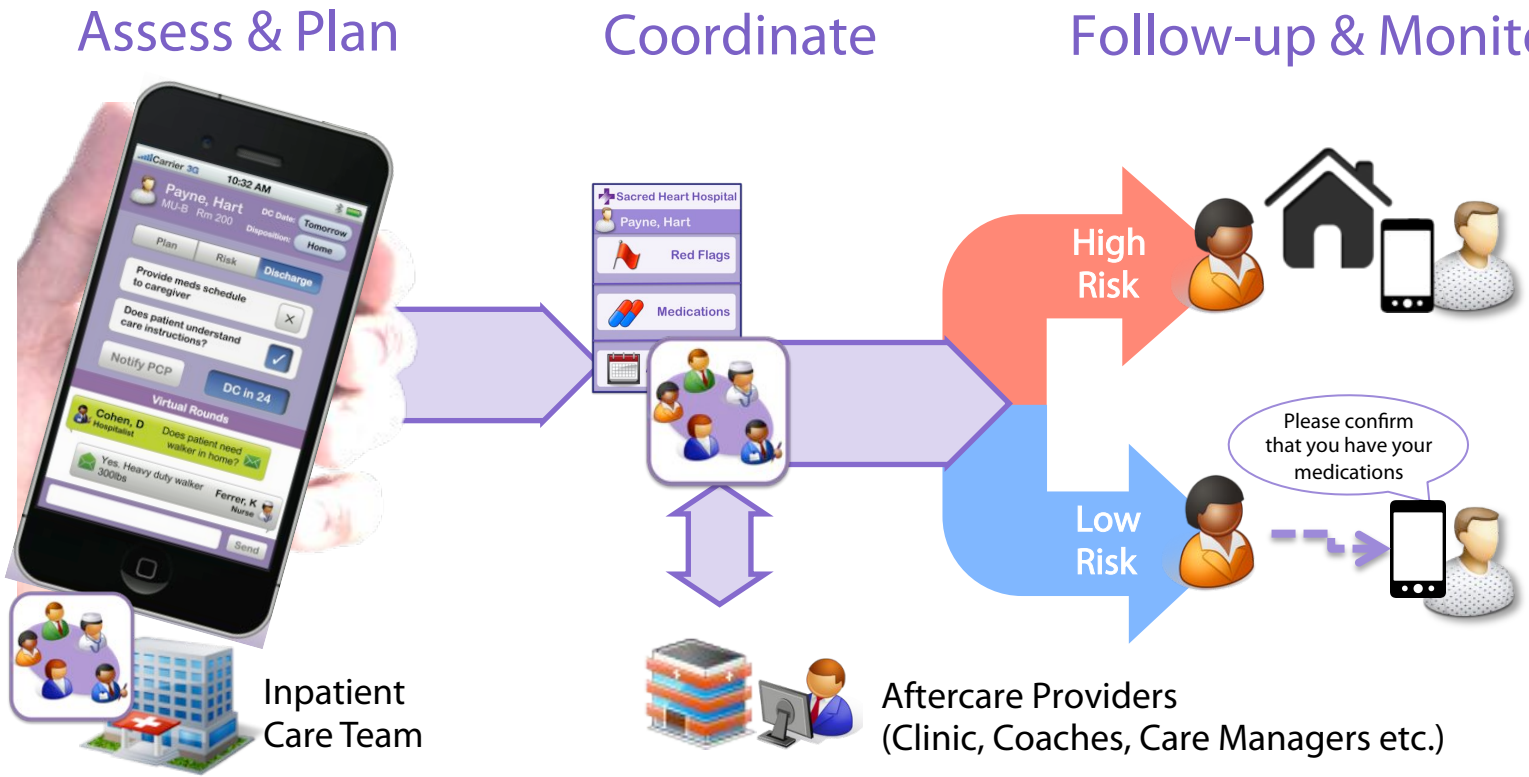


Nation's FIRST Mobile Care Transitions Network™

Team & Evidence-based Multidisciplinary Approach

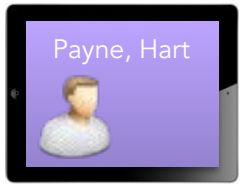


How It Works


Assess & Plan
Coordinate
Follow-up & Monitor
Payne, Hart
Plan
Risk
Discharge
Provide meds schedule to caregiver
Does patient understand care instructions?
Notify PCP
DC in 24
Virtual Rounds
Cohen, D
Does patient need walker in home?
Yes. Heavy duty walker 300lbs
Ferrer, K
Send
Sacred Heart Hospital
Payne, Hart
Red Flags
Medications
High Risk
Low Risk
Please confirm that you have your medications
Inpatient Care Team
Aftercare Providers (Clinic, Coaches, Care Managers etc.)

Carebook Concepts I

Shared, Dynamic Checklists with Real-Time Notifications*



2+ Hospitalizations in 6 months

Limited Social Support

Substance Abuse

Limited Transportation

Cognitive Impairment

No PCP

Limited or No Insurance

Failed Teach-back

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

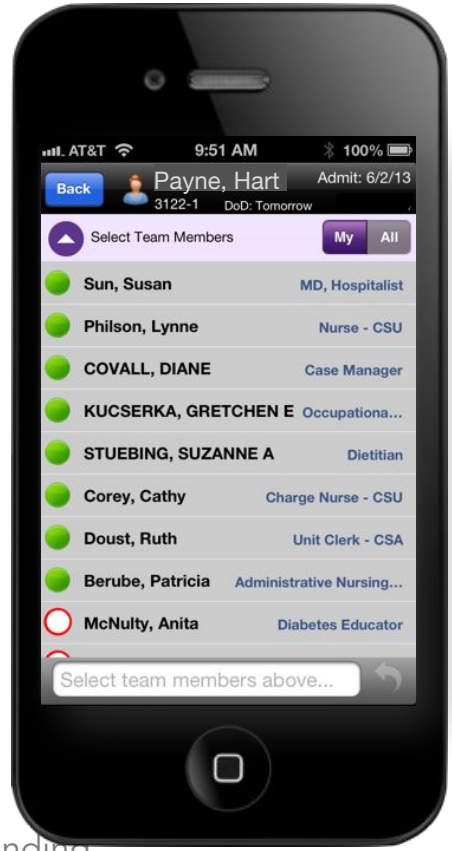
Social Worker

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

Coach Coordinator

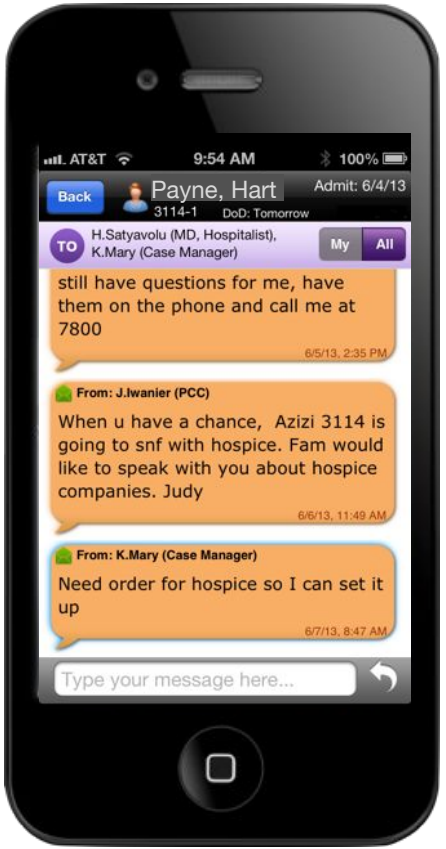
*Patent Pending

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

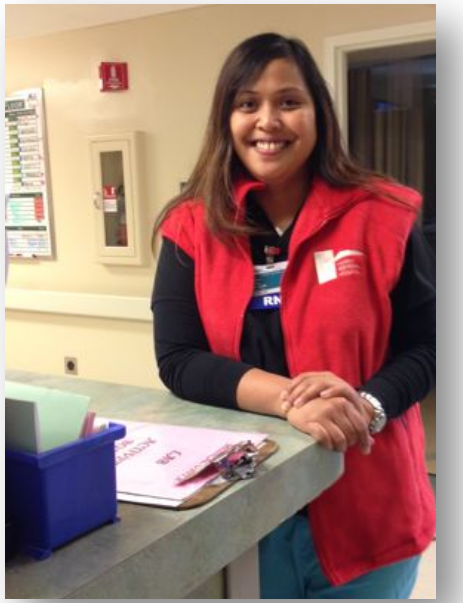


*Patent Pending

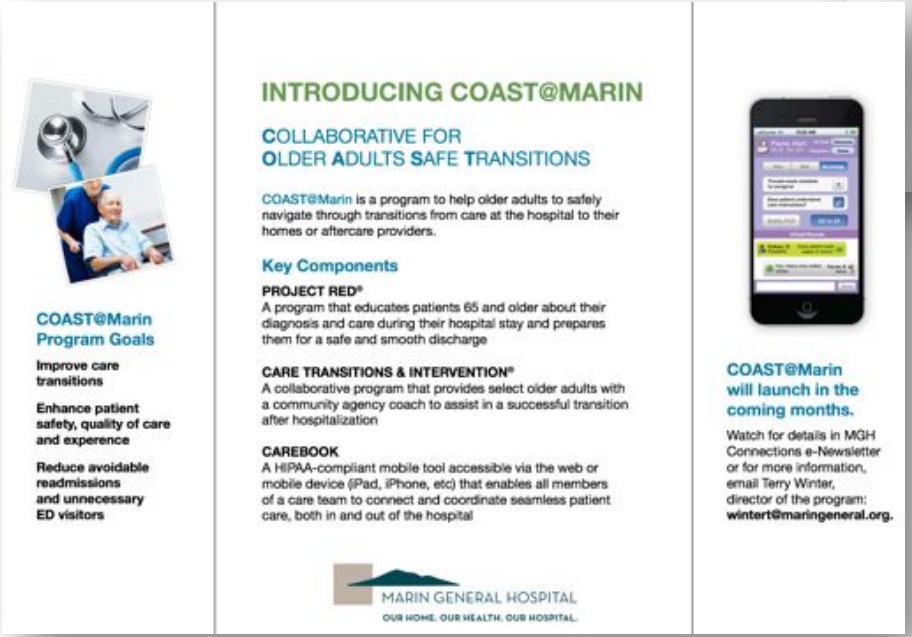
Hospital Mobile Technology Deployment

- 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

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



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

MARIN GENERAL HOSPITAL
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.**

MARIN GENERAL HOSPITAL

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
ployee 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

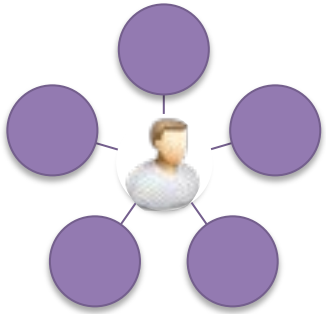
The Proof

More 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 discharge plans” (MDs)	8%	72%

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

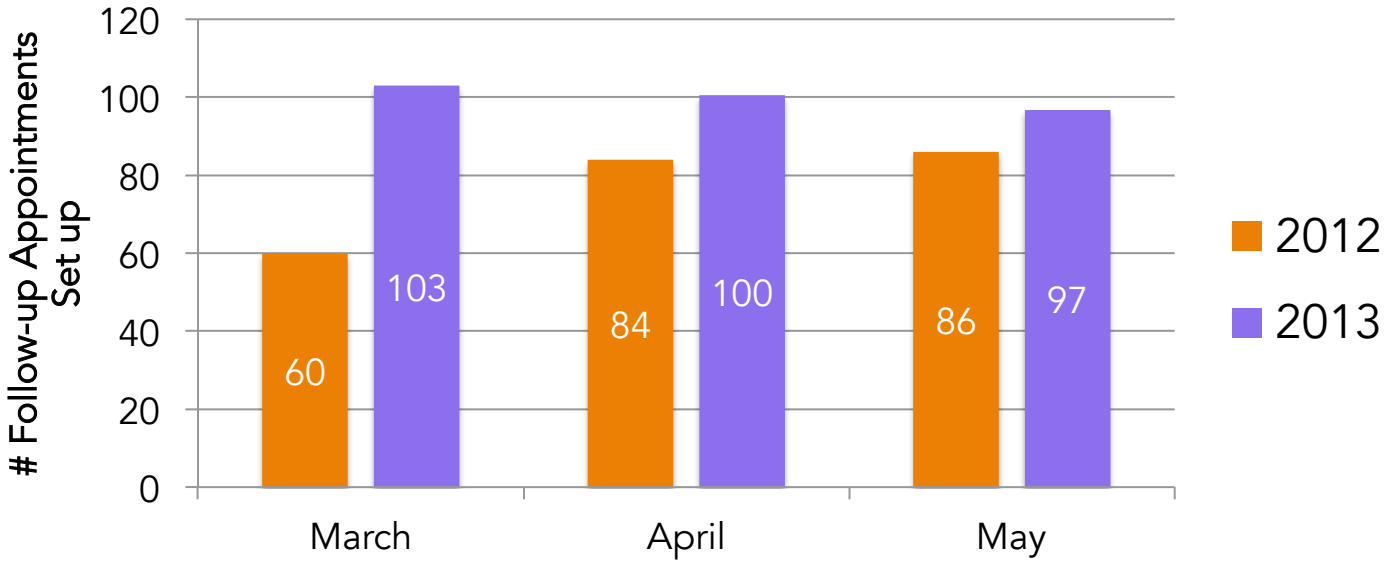
Better Communications in Less Time



80% communications were in patient context

65% reduction in pages

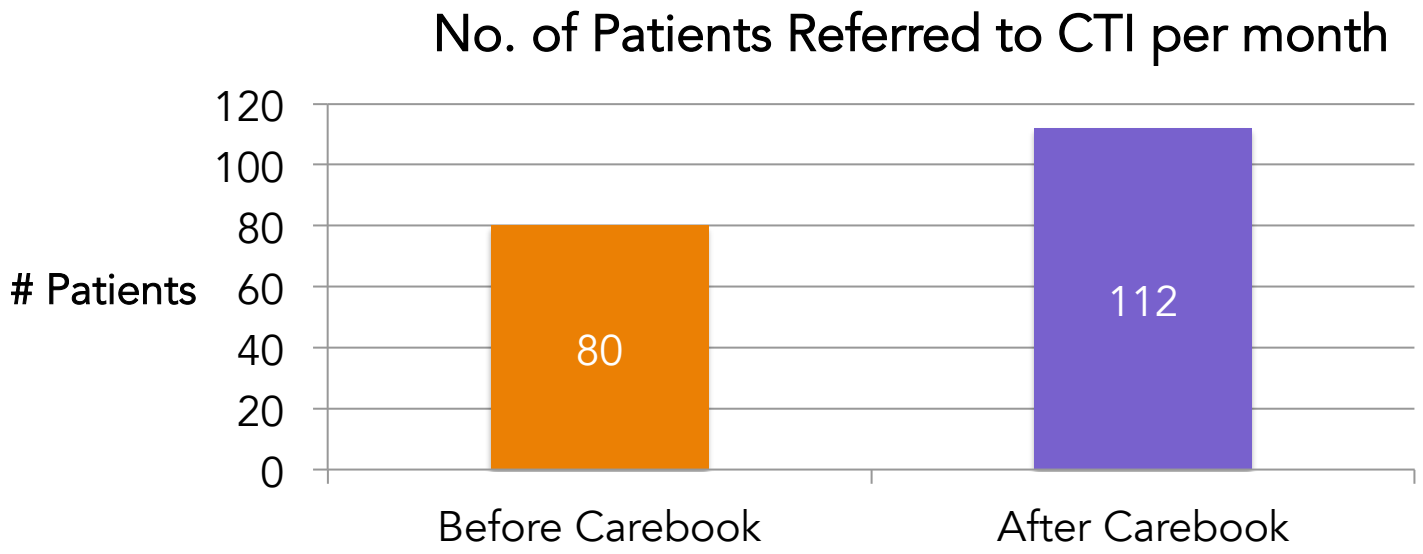
More Follow-ups Scheduled



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

More appointments being scheduled prior to discharge

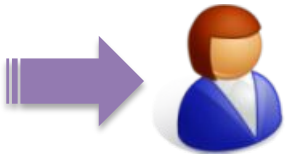
More Coaching Referrals



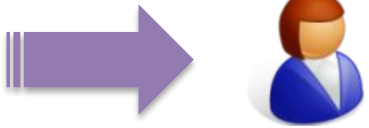
40% increase in patients referred with Carebook

Medication Discrepancies Intercepted

13%



Assessed for Coaching Eligibility



39%

of coached patients had a medication discrepancy discovered

Improved Readmission rates, HCAHPS, ALOS & more

Better Care

readmissions

22%

18%

patient satisfaction

6,000

patients received better care over eight months

Lower Cost

ALOS

½ day

60 min

extra clinician time

Staff Morale & Productivity:

"I feel naked without my Carebook" – RN Case Manager
"I don't know how I would live without it" – Bedside Nurse
"I love Carebook!" – Hospitalist MD

What have we learned?
The Gems

Multidisciplinary approach eases adoption

"We built it together"

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

Viral adoption of communication due to efficiency

"I want to be on Carebook"

Carebook: a dynamic tool for front-line innovation

Rapid PDSA cycles with real-time performance tracking

Safer & Efficient care transitions