personifycare

St John of God Healthcare

Deploying new models of care to reduce re-admission rates with digital pathways

Whilst they're not new to the healthcare system, the growth of hospital substitute and care at home programs has accelerated in recent years.

ST JOHN OF GOD Healthcare at Home

Many of the barriers to the widespread adoption of these programs have dissolved as health technology becomes more accessible and community expectations have shifted to a personalised, technology-enabled healthcare experience.

The Program

St John of God Health Care was ahead of the curve when their Healthcare at Home service collaborated with St John of God Murdoch Hospital in Perth in 2019, to put in place a program to reduce the number of preventable re-admissions. Named the Preventable Re-admissions Pilot Project, the program's aim was to provide end-to-end care – hospital to home- for patients identified as a high risk of re-admission. This was to be achieved though targeted delivery of community-based clinical support post-discharge, resulting in avoidance of preventable re-admissions.

An early iteration of the program was introduced for moderate and high-risk patients on the hospital's general surgical ward. Identification of, and monitoring patients was a very manual and time-consuming process, as the ward nurses had to complete a manual screening tool which then was collected by the Healthcare at Home team who were then phoning the patients post discharge and identifying any risk of readmission.

The nurses were already time poor and some patients missed in the process, so finding a more agile solution that could be rolled out was a high priority. The solution would need to be easy to use so that every opportunity could be taken to support any patient potentially at risk.

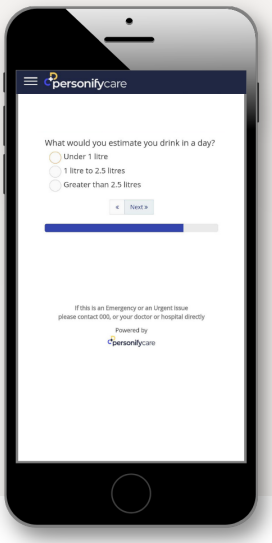
To ensure long term sustainability of the program, the St John of God Healthcare at Home team identified the need to engage a digital platform to streamline these inefficiencies, and in May 2021, Personify Care was selected. Since the introduction of Personify Care's digital patient pathways, St John of God Healthcare at Home has been able to extend the reach of their program to more patients and more wards whilst supporting their patients in their recovery at home.

The Technology

Personify Care is a mobile-friendly platform that allows health services to plug in their existing pre-admission and post-discharge protocols to monitor the preparation of patients in the lead up to a surgery, collect health history information, and then digitally check in to make sure they're recovering well at home after they've had a procedure.

Patients admitted to St John of God's Healthcare at Home Preventable Re-admissions Pilot Program remain under the medical governance of the hospital for 14 days post-discharge. Digitally enabling this care model has supported the program's remote health management protocols and enables patient self-management activities and visibility of the early indicators of patient deterioration.

- Patient is discharged from SJGHC Hospital and invited into the SJG Healthcare at Home program.
- They're sent an SMS notifying them of the program and inviting them to register on the Personify Care platform.
- Once the patient has registered, then they will receive their first assessment within 24 hours.
- After completing the assessment, if the patient triggers a red flag, then nursing staff will contact them to assess how they are recovering, provide education and escalate care as needed.
- Patients will also receive assessments at day 7 and day 14.
- Day 15, the patient receives a Patient Reported Experience survey



In between assessments, the patients can send messages to staff via the Personify Care app if they have any concerns. Our experience is that once patients get home they have questions regarding pain management, bowel movement and hydration, some of which are answered by health management education leaflets automatically sent to patients via the app.

Nursing staff are also able to see which patients have triggered red flag alerts, through the Personify Care staff dashboard and can thus target their time to these patients with need for additional care.

"If there's something major going on and we think they need a visit, we'll organize a home visit with them. Because we have nursing staff that are undertaking home visits over seven days of the week we can readily schedule a home visit for the program patients as required. So within the next day the patients will receive a visit from a nurse. If there's something that needs to be escalated to their doctor, then we'll ring their doctor and chat through any issues identified and we also may organise for the patient to go and see their doctor in their rooms."

SIMONE SCALES
PROJECT MANAGER, ST JOHN OF GOD HEALTH CARE

The Outcomes

St John of God Hospital at Home has been able to extend the reach of the program to all patients on the general surgical ward at Murdoch Hospital - not just moderate to high-risk patients.

The extension of the program has been made possible due to the following efficiencies brought about by the use of Personify Care:

- Automatic digital patient check-ins
- Targeted clinical time to patients who need support, based on their reported progress
- The ability to flag patients to the next nurse on shift and leave notes
- The ability to send self-management information and education to patients

The benefits to the staff, program and patients:

- Increasing team efficiency (by decreasing administrative workload and focusing staff time on the patients who need it the most)
- Effectively managing larger patient volumes (extending the reach of the program)
- Reducing cost of care for patients (associated with complications and re-admissions)
- Supporting the new model of care (by leveraging digital efficiencies and overcoming resource barriers)
- Reducing re-admission rates (by facilitating earlier intervention)
- Improving the patient experience and satisfaction (keeps patients tethered to the hospital and is a source of readily available patient information)
- Boost patient engagement and empowering them (by giving them the accessible tools and information they need to understand and self-manage their recovery)

Patients have reported feeling more supported in their recovery once they've left the hospital, and staff have expressed their happiness with the technology.

> *"It's now much easier to manage patients. Personify Care has brought efficiencies to the program such as the speed in which nurses can register patients and the ability to quickly see which patients need additional care."*
>
> **SIMONE SCALES**
> PROJECT MANAGER, ST JOHN OF GOD HEALTH CARE

Summary

The virtues of at-home models of care, which enable remote management and health education, become even more pronounced in today's COVID-19 world. They allow the flow of clinical information from patient to healthcare provider to remain intact, even when the patient is not physically in the healthcare setting. This in turn helps minimise the risk of COVID-19 transmission and frees up bed capacity for acutely unwell patients whilst maintaining a high level of care and limiting the risks associated with transitions in care.

Supporting patients in their recovery also leads to reductions in re-admission rates and improved health outcomes.

Personify Care technology has enabled the delivery of these at-home models of care at scale. The technology brings efficiencies to the program, without the need to redesign protocols. It also provides healthcare staff with early indicators of patient deterioration so they may target their time and resources to caring for the patients who need it most and prevent unnecessary re-admissions.

The technology has been shown to be successfully adopted across patient cohorts, including older and high-risk patients. This supports the change in community expectations as it leans ever closer to the widespread use of technology in our day-to-day interactions.

> *"Older patients are happy to use mobile service and if they're not tech savvy, then their partner usually is."*
>
> **SIMONE SCALES**
> PROJECT MANAGER
> ST JOHN OF GOD HEALTH CARE

Conclusion

The use of technology to support and extend the reach of new models of care has been shown to be effective. After the successful rollout of the Healthcare at Home Program and Personify Care within the general surgical wards at Murdoch Hospital, St John of God are now looking to extend the program to a number of other surgical specialty wards at the hospital, including Urology and Gynaecology.