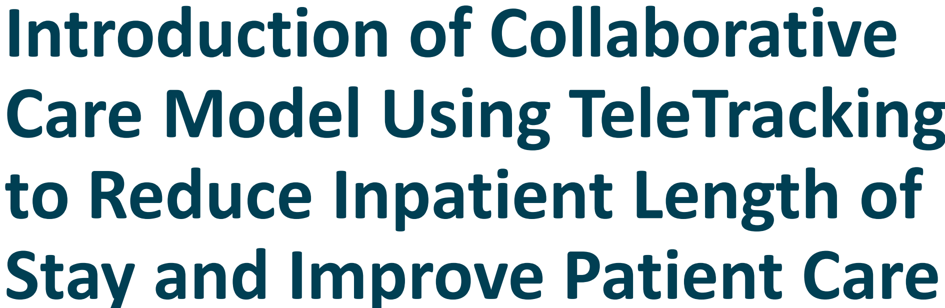
TELECON20



Introduction of Collaborative Care Model Using TeleTracking to Reduce Inpatient Length of Stay and Improve Patient Care

Leah Gehri, Director, Santa Rosa Memorial Hospital, Santa Rosa, CA

Michael Hill, MD, President, MHMDAA Consulting

Contact: Michael Hill, MD – 415.559.8616

WELCOME TO TELECON20!

HERE ARE SOME TIPS TO IMPROVE YOUR VIRTUAL EXPERIENCE

- Use the Microphone icon to switch your audio connection type.
- To ask a question, please use the Session Q&A in WHOVA, or if you would like ask your question verbally, click the raise hand button and your microphone will be unmuted via the facilitator.

IF YOU ARE EXPERIENCING ANY TECHNICAL ISSUES, PLEASE POST YOUR ISSUE IN "ASK ORGANIZERS ANYTHING" COMMUNITY BOARD.

INTRODUCTION

- Leah Gehri, MHA MN RN NEA-BC, Operations Director
  - Leah has nearly thirty years of nursing experience, spending many years at the bedside as a critical care and emergency nurse. As a leader she has focused on key operational improvements in throughput, designing and implementing processes and associated technologies to achieve targeted goals.
  - She received her Bachelors of Science in Nursing from Pacific Lutheran University in Parkland, Washington, her Masters in Nursing (MN) and her Masters in Health Administration from University of Washington. She is currently the Director of Operations at Santa Rosa Memorial in Santa Rosa, California, where she has oversight and responsibility for the Emergency Department and Operations Resource Center.
- Michael Hill, MD, FACEP, President/CEO Michael Hill, MD and Associates, Inc
  - Dr. Michael Hill, with his teams, has spent the last 25 years developing,, comprehensive solutions of advisory and workflow expertise used in conjunction with technology-enabled tools to improve the efficiency, service delivery and predictability of all patient care hospital operations.
  - Dr. Hill is a residency trained emergency physician from UCLA, practiced clinically for 15 years, and directed the operations for a 52-hospital EM group for more than a decade. For the past 24 years, he has led more than 180 hospital operations consulting engagements across North America with a focus on improving operations and patient experience in ED, inpatient, perioperative, and key ancillary areas.

SESSION OVERVIEW & OBJECTIVES

- Burning Platform
- Collaborative Care Model
- TeleTracking Components and Accountability
- Results
- Next Steps

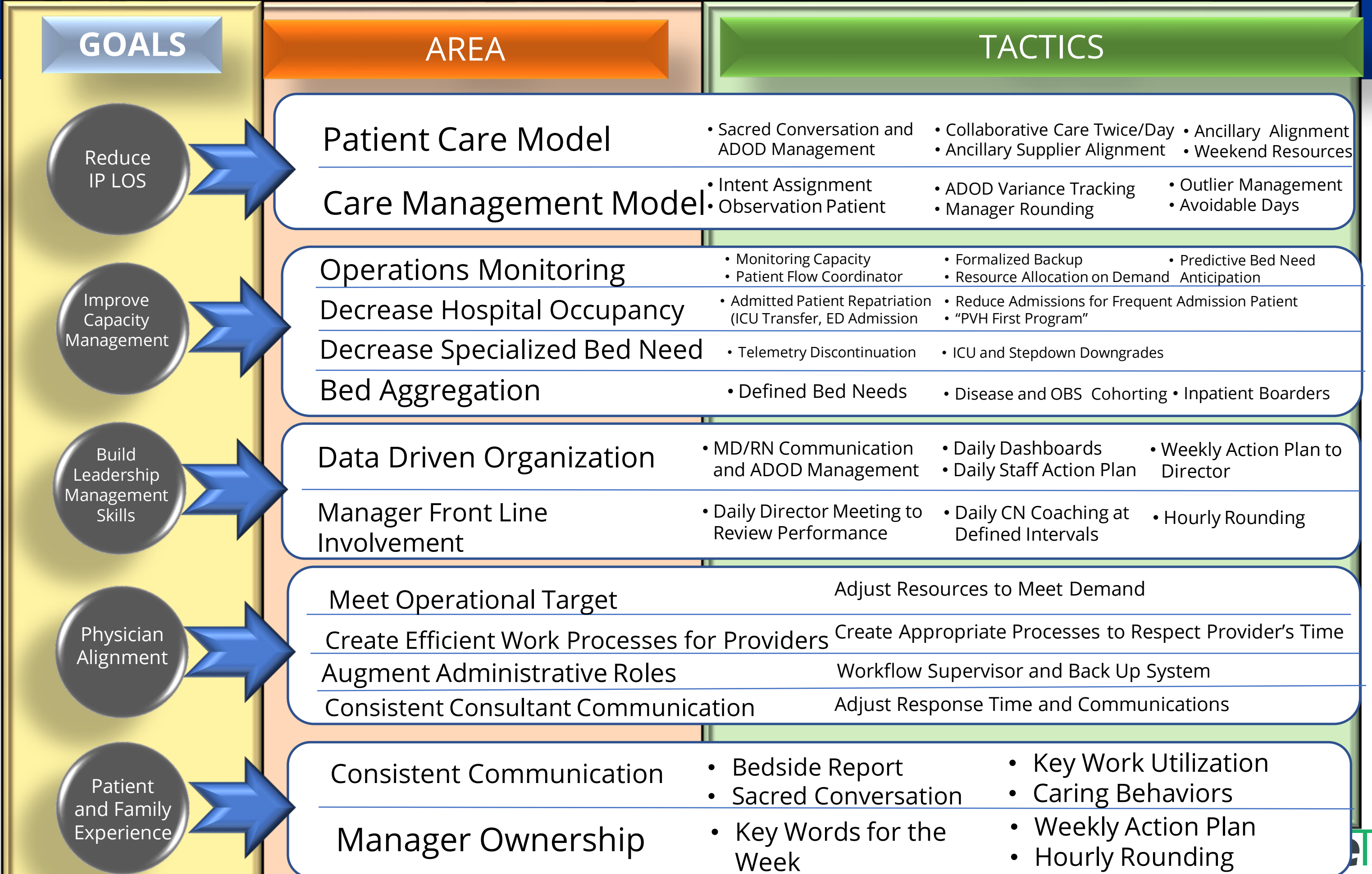
Santa Rosa Memorial Hospital

- 60 miles north of San Francisco
- 283 licensed beds, with ADC 170
- 12,000 Discharges/Year with 50% Medicare
- Average LOS – 6 days with 10 hospitalist/day
- Closed ICU with Intensivist Group
- 33,550 ED Annual Visits (Pre-Covid)
- Use of TeleTracking Capacity Management Suite

CASE STUDY: PROBLEM / CHALLENGE

- Long LOS (6 days) with low patient experience scores despite an 18 - month initiative to reduce LOS
  - Anticipated Date of Discharge not driver for discharge
- Variability in hospitalists practice patterns
- Attempt at 0830 Huddle with hospitalists with Lead Nurse and Case Manager not described as effective
- Ancillary Services (Rehab/Resp/EVS/Lab/Imaging) not aligned to move patient through system
- Post-Acute Care planning impact on LOS
- Solution – Defined business rhythm for all constituencies aligned to ADOD

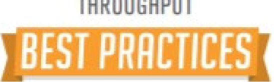
Collaborative Care Model Strategy



eTracking

TeleTracking Discharge Planning Best Practices

- Historical initiatives on discharge planning link to next day prediction of discharge too late in process



THROUGHPUT

BEST PRACTICES

TACTICS

Start discharge planning the day of admission to enable safe and efficient patient discharge supported by transparency & real-time visibility of discharge progress

powered by Capacity Management Suite™

1. Institute a 24-hour discharge prediction bundle to accurately predict discharges for the next day to create earlier access for waiting patients.
   - Multi-Disciplinary Rounds should include 24-hour predictions.
   - Identify 11am and 2pm discharges with contingent needs the day before.
   - Nursing/Case Management should conduct a 5 minute afternoon huddle to verify contingent needs are being met for early discharge.
   - Utilize PatientTracking Portal for the 24-hour charge nurse to charge nurse handoff.
   - Formalize reporting of yesterday's discharge results during safety meeting or bed meeting.
2. Identify early discharges for the following day to ensure the Provider writes the order early to assist with earlier discharges and increased bed availability.
3. Communicate the patient's Projected Discharge Date with the patient and family daily throughout the patient's stay to avoid any potential delays in discharge.

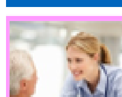
- Use of TeleTracking by Charge Nurses during report
- Daily Communication of Anticipated Date of Discharge

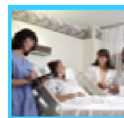
Discharge Core Work Activities

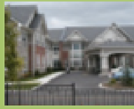
1 On Patient Admission	2 Day After Admit	3 Daily Care	4 3 Days Prior to Discharge	5 2 Days Prior to Discharge	6 Day Prior to Discharge			7 Day of Discharge				8 Discharge Monitoring
					External Needs	Afternoon MD Communication	Evening Shift Activities	Results Availability	Charge Nurse Prioritization	MD Discharge Order	Patient Departure	
Physician/ Care Team defines preliminary Integrated Plan of Care & ADOD within 24 hours Family Centred D/C Process Overview Standard Patient Assessment Community Support Assessment Completed Initiate Medication Reconciliation Process	Family Physician and Home Care notified of IP admit Flag patients with planned community support needs Obtain Family Physician Problem List/ Medication	Physician/ Charge Nurse/ Team Integrated Plan of Care Review with ADOD Physician sees & communi-cates with patient/ Charge Nurse "Steps to Home" Review Daily Patient Whiteboard ADOD Update Bedside Report	Specialized D/C Pre-Planning Needs identified Physician declares Day of D/C or Day Prior to D/C for family communication Heads up/ communication with receiving facility EMS notified of complex D/Cs	Family Notification of Planned ADOD & Planned Family Arrival Time Inpatient Eval for Home Care Referral Care Coordinator works with care team & external resources to remove barriers to D/C "Consultant Heads Up" ADOD "Move Ups"	Care Coordinator will notify the External Care Facility of pending D/C Next Day Ambulance Request and ETA Community Supports in place	Next Day "Green Flag Physician" Call: Confirm follow up home care need Conditional D/C Order or Conditions for D/C Medication Reconciliation "Blister Pack" within 24 hours of D/C time Pass meds ordered Prescription Writing Transfer Summary complete Next Day physician ETA Schedule follow-up appointment	"Family Final Plan" Notification of Next Day D/C Preliminary ETD identified Next Day ADOD Imaging completed	0630 Critical Care and Surgical Unit 0730 Medical Unit	"Charge Nurse and Physician Huddle" MD, Family and EMS ETA Monitoring	Surgical Service Physician D/C Order: 0700 Medical Service Physician Order: 0900 Family Arrival: 0900	Ambulatory Surgical Patient Departure: 0900 Ambulatory Medical Patient Departure: 1100 Transfer Bundle by 0630 Mental Health (place-holder) **EMS Patient Departure** EMS Patient Pick-up per iRequest	Patient & Care Team given D/C Summary/ Integrated Plan of Care/D/C Checklist (place-holder and complete medication list Home Care notified of inpatient D/C Family Physician and most responsible Community Support Provider receive D/C Summary/ Integrated Plan of Care <24 hours of D/C

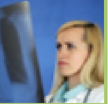
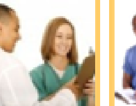
- Standard Patient Assessment, Integrated Plan of Care and ADOD updated by Physician/Care Team daily
- Lab results available in computer by 0630 for Critical Care and Surgical Unit, and by 0730 for Medical Unit
- IP imaging begins at 0600

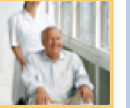
- Real time monitoring of Estimated Time of Departure









Standard Business Rhythm Defined

Hospitalist CN Check In at 0830

Collaborative Care Huddles at 12 Noon and 4 PM

D/C Order by 9 AM

Patient Depart by 11 AM

Sacred Conversations by 1730

Daily Scheduled Hospital Business Rhythm

SRMH Collaborative Care Business Rhythm Calendar

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:00	Early AM Mobility	Early AM Mobility	Early AM Mobility	Early AM Mobility	Early AM Mobility	CC Steering Committee; Early AM Mobility	Early AM Mobility
7:30						CC Steering Committee	
8:00	Surgery Interdisciplinary Rounds	Surgery Interdisciplinary Rounds	Surgery Interdisciplinary Rounds	Surgery Interdisciplinary Rounds	Surgery Interdisciplinary Rounds	Surgery Interdisciplinary Rounds	Surgery Interdisciplinary Rounds
8:30	AM Unit Hospitalist Huddle	AM Unit Hospitalist Huddle	AM Unit Hospitalist Huddle	AM Unit Hospitalist Huddle	AM Unit Hospitalist Huddle	AM Unit Hospitalist Huddle	AM Unit Hospitalist Huddle
9:00	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds
9:30	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds	CC Operations Meeting	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds	ICU Interdisciplinary Rounds
10:00							
10:30							
11:00							
11:30	Collab Care Hospitalist Huddle	Collab Care Hospitalist Huddle	Collab Care Hospitalist Huddle	Collab Care Hospitalist Huddle	Collab Care Hospitalist Huddle	Collaborative Care Hospitalist Huddle	Collab Care Hospitalist Huddle
12:00							
12:30							
13:00							
13:30		Unit Leadership Rounding	Unit Leadership Rounding	Unit Leadership Rounding	Unit Leadership Rounding	Unit Leadership Rounding	
14:00			CM Outlier Meeting		CM Outlier Meeting		
14:30							
15:00							
15:30	CC Hospitalist Walking Rounds	CC Hospitalist Walking Rounds	CC Hospitalist Walking Rounds	CC Hospitalist Walking Rounds	CC Hospitalist Walking Rounds	CC Hospitalist Walking Rounds	CC Hospitalist Walking Rounds
16:00							
17:00	Family Communication for Next Day Planned Discharge Time	Family Communication for Next Day Planned Discharge Time	Family Communication for Next Day Planned Discharge Time	Family Communication for Next Day Planned Discharge Time	Family Communication for Next Day Planned Discharge Time	Family Communication for Next Day Planned Discharge Time	Family Communication for Next Day Planned Discharge Time
18:00							

Legend: =Huddles (green); =Interdisciplinary Rounding (blue); = Collaborative Care Meetings (orange); = Nursing Care (yellow); = Leadership Rounding (pink)

- Key Concept is daily work activities linked to time of day

TeleTracking

Key Components of Collaborative Care Huddles

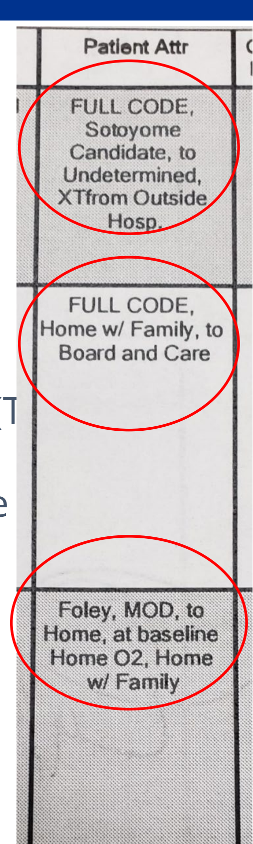
- Between 1130 and 1330, Collaborative Care Huddle for 10-15 minutes with key participates
  - Today ADOD progression and obstacles
  - Planned next day discharges with barrier identification
  - Antibiotic Stewardship/Opiate Medication Protocol/"Med to Bed"/Med Auth from Pharmacy
  - Patient Safety Issues (Foley/Central Line Removal)
  - PT/OT Results
  - 0830 AM MD/Lead/CM Check In Participation
- Between 1530 and 1700, Collaborative Care "Walking Rounds" on individual units for 5-10 minutes with LN/CM/Hospital Administrative Leader
  - Review change in patient progression during the day
  - Confirm next day ADOD patients, any additional barriers to discharge and estimated time of day they will leave
  - Confirm next day transportation
  - Ask how many "Patient-Centered Conversations" occurred and what barriers were encountered
- Tele Units
  - Cath Lab Manager (Tele Units)
  - Downgrade Candidates
- Hospital Administrative Leader escalates issues
- Palliative Care Consultations
- Rehab Unit Evaluation status
- Case Management confirmation of planned disposition

Standard Reports Became Critical Component of Huddles

Diagnosis	Age	LOS	Proj Discharge	Discharge Plan	Family/EMS ETA	Prelim SNF	LOC	Treatment Plan	Comments	Iso Type	Patient Attr	Cardiac Rhythm	Attending Phys
SEPSIS, PNA, CHF EXACERBATION	78	2.8 day(s)	04/25 00:00	Home with oxygen		Accepted back to Apple Valley SNF. Family refusing Apple Valley.	Med Surg Tele	4/21 sepsis PNA. Recent adm 3/15-28 for CHF, RSV. Remote tele, nicotine patch, IV abx, 1L NC. PT/OT. Monitor trops downtrending. Occasional AIVR. EKG SR w/BBB. Dietary consult?, sputum pend, BC NGTD.	STH: PT EVAL dietary consult Per Public Health, surveillance until 4/24, then re-test. If neg results, can go to SNF	Droplet	Fall Precaution, FULL CODE, to SNF, NC<2, D3, Moderate Assistance	SR, VPACE	H[illegible]
VIRAL PNEUMONIA (COVID-10), ACUTE HYPOXIC RESPIRAT	74	24.2 day(s)	04/23 11:00		Wife says pt needs to be independent in and out of bed to come home		Med/Surg	4/21; covid + 3/23 - managed at home. adm 3/28, pulmonologist from Sonoma; hx afib, DM2, HTN; 2 wks intubated ICU; arrived to 1C on 4/17; NC@4L O2; very weak. doesn't qualify for LTAC. plan home w/HH when ready. PO abx taken at home. BG BID.	STH: D/C home w/wife & HH COVID results not documented in serology Needs home 02 Wife needs pt to be nearly independent to safely go home If SNF is required pt would need 2 negative tests Home Monitoring for COVID	Droplet	Fall Precaution, FULL CODE, to HHC, NC>2, From Home w/ Family, D3, Family Communication, Minimum Assistance, Confirmed during Stay		C[illegible] Je[illegible]
COVID-19 PUI,SEPSIS,ATYPICAL PNA	72	19.0 day(s)	04/25 00:00	Home instead of SNF, due to COVID testing	4/13 @ 14:00 called patient's daughter, Kahn and discussed possible but unlikely	SNF; Vinyard Post Acute after 2 negative Covid tests. VS; home w/ family and home care	Med Surg Tele	4/21 COVID+. MWF dialysis; Remote Tele. On RA. blind; DC Home w/ HH vs SNF after 2 consecutive negative COVID screenings. FWW 1 person, incont. Speaks Laotian only. working with PT. COVID retest 4/16 PCR is +/Detected. Repeat test 4/23 needed.	COVID(+) PUI# CA49013439 STH: Positive COVID, 2 consec Neg tests for SNF/OP HD acceptance. COVID retest 4/16, positive. Will retest 4/23 and then a second negative 24 hours after Interpreter machine broken	Droplet	Hemodialysis, Fall Precaution, FULL CODE, to SNF, From Home w/ Family, D3, Family Communication, Moderate Assistance, Presumed on Adm, Confirmed during Stay		C[illegible] Je[illegible] e

Using TeleTracking Reports to Accelerate Communication

- Level of Care -
  - Telemetry Identified
- Patient Attributes Help
  - Foley
  - Central line
  - Code Status
  - Origin (From)
  - Disposition Destination (T
  - Oxygen
  - “Meds to Bed” Candidate
  - Special Home Needs
  - Sotoyome Candidates



- Ready for Discharge (RFD) Report
  - Distributed Daily to CM/Lead Nurse/Manager/Physician Leader/AOD/CM and Hospital Senior Leaders
  - Updated every Huddle with MD Assignment

PatientTracking Portal™

TeleTracking

Care Progression Worklist

09/29/2020 06:45

BURROWSJN1

This report is designed for supervisors to be able to run a quick report at the beginning of the day to see which patients they (and/or their team) need to see today, and the status of each patient. This report is a tool that helps supervisors plan their work and resources for the day.

Report Parameters: Campus: Santa Rosa Memorial; Units: All units associated with the selected campus; Care Progression Group: Ready for Discharge; Care Type: All Care Types associated with selected care progression group; Status(es): All Statuses associated with selected care progression group; Show Only Delayed: No.

*Note: **- Delayed*

Patient	MRN	Visit Number	Isolation	Patient Status	Bed	Care Type	Status	Delay Reason	Ordered Date	Attending Physician
1C										
WH MA	SM 3	SV 478	Respiratory Illness	InHouse	1C180-01	Non-SNF Refusal	In Progress**	Refusing to Accept Patient Back	09/25/2020 11:40:18	Pall
RIC JAI	SM 1	SV 801	Respiratory Illness	ConfirmedDischarge	1C172-02	SNF Refusal	In Progress**	No Accepting Facility	09/23/2020 11:37:11	Dov
FLC PA	SM 5	SV 138	Respiratory Illness	InHouse	1C185-01	SNF Refusal	In Progress**	No Accepting Facility	09/25/2020 11:33:22	Pall
RO	SM 3	SV 697	Respiratory Illness	InHouse	1C180-02	SNF Refusal	In Progress**	No Accepting Facility	09/25/2020 11:34:36	Cur
ELI	SM 8	SV 751	Respiratory Illness	InHouse	1C178-02	SNF Refusal	In Progress**	No Accepting Facility	09/25/2020 11:35:25	Dov
HA	SM 7	SV 666	Respiratory Illness	InHouse	1C182-02	SNF Refusal	In Progress**	No Accepting Facility	09/25/2020 11:35:43	Dov
BIS	SM 0	SV 969	Respiratory Illness	InHouse	1C178-01	SNF Refusal	In Progress**	No Accepting Facility	09/25/2020 11:40:47	Ale

Patient Care and Discharge PrePlanning TeleTracking Icons

Patient Care Treatment Icons
- Patient Treatment
- Safety Issues
- Special Needs

Disposition Planning Icons - LOS, ADOD, Planned Disposition, Home Health Needs, SNF Status (Preliminary and Confirmed) and Family Communication ETA and Icon, Isolation Status

Disposition Icons

Demographics/COVID/ MD/ Consultant/ Diagnosis

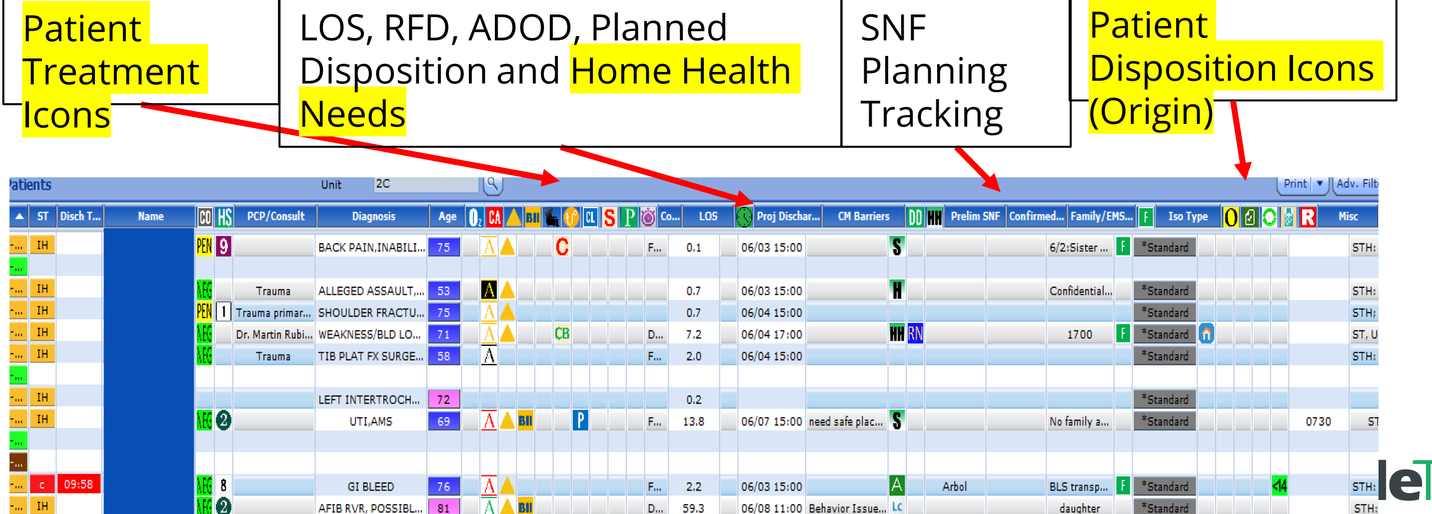
atients   Unit 2C   Print ▾ | Adv. Filt

▲	ST	Disch T...	Name	CO	HS	PCP/Consult	Diagnosis	Age	O_2	CA		BII			CL	S	P		Co...	LOS		Proj Dischar...	CM Barriers	DD	HH	Prelim SNF	Confirmed...	Family/EMS...	F	Iso Type	O				R	Misc	
-...	IH			PEN	9		BACK PAIN,INABILI...	75		A				C					F...	0.1		06/03 15:00		S				6/2:Sister ...	F	*Standard							STH:
-...																																					
-...	IH			NEG		Trauma	ALLEGED ASSAULT,...	53		A										0.7		06/03 15:00		H				Confidential...		*Standard							STH:
-...	IH			PEN	1	Trauma primar...	SHOULDER FRACTU...	75		A										0.7		06/04 15:00								*Standard							STH;
-...	IH			NEG		Dr. Martin Rubi...	WEAKNESS/BLD LO...	71		A				CB					D...	7.2		06/04 17:00		HH	RN			1700	F	*Standard							ST, U
-...	IH			NEG		Trauma	TIB PLAT FX SURGE...	58		A									F...	2.0		06/04 15:00								*Standard							STH:
-...																																					
-...	IH						LEFT INTERTROCH...	72												0.2										*Standard							
-...	IH			NEG	2		UTI,AMS	69		A		BII			P				F...	13.8		06/07 15:00	need safe plac...	S				No family a...		*Standard						0730	ST
-...																																					
-...																																					
-...	c	09:58		NEG	8		GI BLEED	76		A									F...	2.2		06/03 15:00		A		Arbol		BLS transp...	F	*Standard					<14		STH:
-...	IH			NEG	2		AFIB RVR, POSSIBL...	81		A		BII							D...	59.3		06/08 11:00	Behavior Issue...	LC				daughter		*Standard							STH:

= RN Responsibility to Update Daily

TeleTracking Discharge Planning Overview

- TeleTracking gives real-time transparency to patient status so that Lead Nurse, Patient Care Nurse, and Case Manager can immediately see the current planned discharge date (Anticipated Date of Discharge or ADOD), planned disposition, SNF destination and status , and “Steps to Home” (barriers to discharge)
- Other Discharge Planning information includes: Current LOS, if patient is “Ready for Discharge” (RFD) (does not meet medical need for acute care hospitalization), Home Health Needs, SNF Status, if Family have been Communicated with for discharge and planned family next day arrival time
- Case Manager reviews at beginning of each day to review and prioritize work prior to 08:30 Meeting
- Pending/Confirmed Discharge status and Discharge Timer were activated previously



TeleTracking Patient Care Icons – A Primer

- Acute Care Management
  - RN - Patient Care - COVID Status, O2 Use, Fall Risk, Ambulation Status, Code Status
  - RN - Safety Issues – Behavioral Health, Restraints, Sitter, Central Line, Foley
  - RN - Special Needs – Radiation, Chemotherapy, Hemodialysis, Palliative Care
- Disposition Planning
  - LN - “Steps to Home”
  - LN - If LOS > 0.8 days
    - ADOD
    - Planned Disposition
  - CM - If Potential SNF Disposition and LOS > 1day
    - Preliminary SNF
    - CM Barriers
  - Admitting RN - Origin
  - UM RN - Readmission
  - LN - Sotoyome Candidate
  - LN – “Meds to Bed”
  - CM – “Take Back Agreement
- Day of Discharge Planning
  - LN - Projected Discharge Time in ADOD Column
  - CM - If SNF Disposition
    - Preliminary SNF Name
    - SNF Confirmation Date
    - EMS ETA
  - RN - If Discharge Home
    - Family ETA
    - Family Icon indicating next day arrival time communicated to family

Icon	Meaning	Icon	Meaning
O_2	Oxygen	C	Code Status
CA	Current Ambulation		Ready for Discharge
	Fall Precaution	DD	Discharge Disposition
BH	Behavioral Health	HH	Home Health
	Sitter	F	Family Communication
	Foley/Catheter	O	Patient Origin
CL	Central Line		Sotoyome Candidate
S	Special Needs		Take Back Agreement
P	Palliative Care		Meds to Beds
	Sepsis	R	Readmission

Nurse TeleTracking Roles and Responsibilties

Floor Nurse

At Time of Patient Intake/Admission the Floor Nurse Activates the Below TeleTracking Icons:

- Hospitalist Service
- Patient Origin
- Oxygen Requirements
- Isolation Type
- Code Status
- "PVH First" Candidate
- Take Back Agreement Candidate
- Foley
- Central Line

As Patient Care Progresses The Floor Nurse Updates Above Icons and:

- Activates Discharge Disposition Icon
- Palliative Care Involvement (if applicable)

Lead Nurse

During Patient Admission/Inpatient Transfer Process the Lead Nurse Inputs the Below Into TeleTracking:

- RTM/RTA
  - RTA for incoming unit transfers and RTM for outgoing transfers

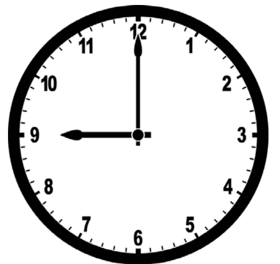
During 1200 and 1600 Collaborative Care Huddles the Lead Nurse:

- Brings 4 copies of Unit Daily Printout to Collaborative Care Huddles
- Inputs/Updates ADOD/ADOT
- Inputs Ready for Discharge (RFD) Coupled with Associated Discharge Delay Reason (if applicable) based on Physician Direction
- Inputs Patients Steps to Home in Comments Section
- Updates any Icon Based on Collaborative Care Discussion

TeleTracking®

Establishing TeleTracking Accountability - Nursing

Manager Reviews TeleTracking with LN at beginning and end of day



Manager attends Huddle and helps LN place content into TeleTracking real time.

Manager "Check In" and "Check Out"

- COVID status
- Patient Care Icons
    - Patient Care
    - Safety
    - Special Needs
    - Level of Care (Remote Tele, etc)
- ADOD if > 1-day LOS
- Planned Disposition if > 1-day LOS
- Family Communication
- Family ETA

Manager 'Huddle Partner"

- ADOD
- Planned Disposition
- Home Health
- "Steps to Home"

Establishing TeleTracking Accountability – Administration of the Day

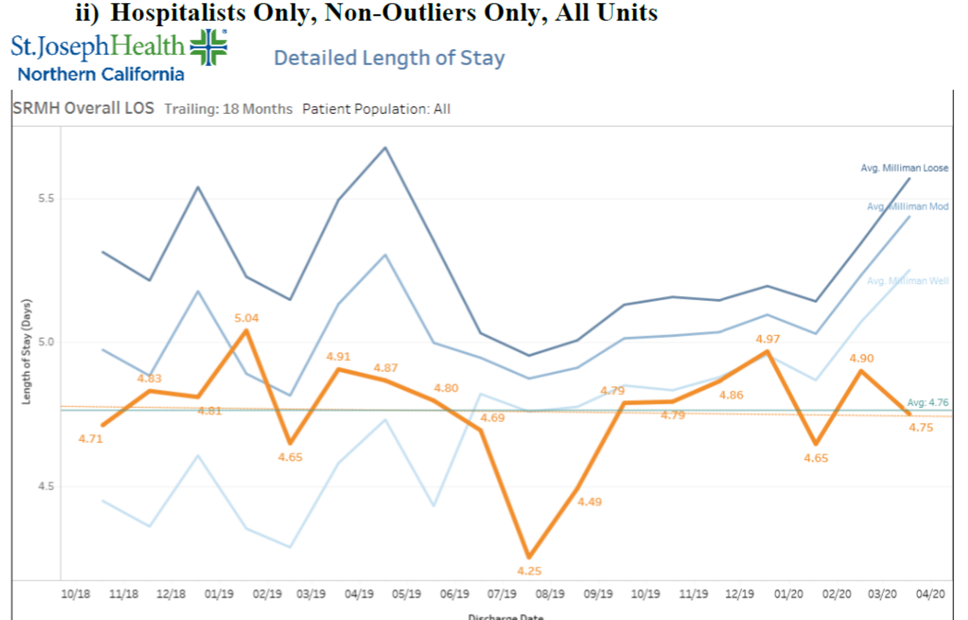
AOD attends Huddle, reviews TeleTracking and ensure that LN place content into TeleTracking real time and that key components of TeleTracking are completed.

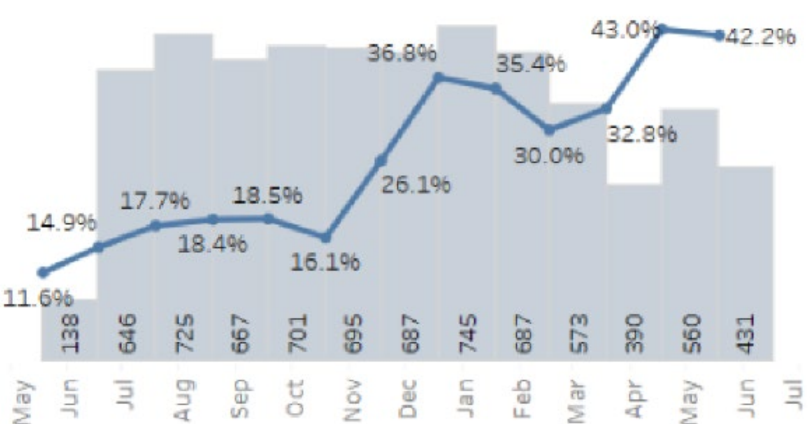
- If incomplete, AOD asks LN to contact Manager to help in completing TeleTracking in next hour
  - If Manager not available, ask LN to contact Back Up Manager
  - If Back Up Manager not available, asks LN to contact Director

AOD Huddle "Check In"

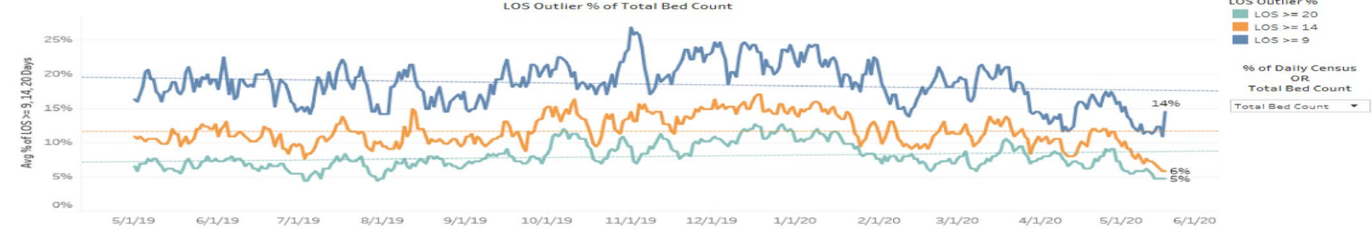
- Patient Care
  - COVID status
  - Patient Care Icons
    - Acute Care Management
    - Safety Issues
    - Special Needs
- Disposition Planning
  - "Steps to Home"
  - If > 1-day LOS,
    - ADOD
    - Planned Disposition
  - If Home Health, Type of Home Health
  - If Potential SNF Disposition and LOS > 1-day, and < 5 days
    - Preliminary SNF
    - SNF Acceptance
  - CM Barriers
  - Preliminary SNF
  - Ready for Discharge ('RFD' Flag)
- Day of Discharge Planning
  - Medical Transport Icon for Planned Medical Transports and EMS ETA
  - Family ETA and Family Icon Use

Collaborative Care Initiative Outcomes





- LOS ½ day below "well managed benchmark"
- 50% reduction in LOS outliers
- Discharge Orders before 9 AM from 11% to 42%
- No increase in Readmission Rates



Patient Experience Improvements

- Increased scores for nursing and information on discharge process and information

Nurses Section

Inpatient
Santa Rosa Memorial Hospital
Adjusted Mean Score Percentile Rank by Discharge Date
Peer Group: All Hospital DB; by All Respondents
Nurses Section

75
50
25
0

May'19 Jun'19 Jul'19 Aug'19 Sep'19 Oct'19 Nov'19 Dec'19 Jan'20 Feb'20 Mar'20 Apr'20 May'20

CAHPS - Discharge Information

Inpatient
Santa Rosa Memorial Hospital
Adjusted Top Box Percentile Rank by Discharge Date
Peer Group: All Hospital DB; by All Respondents
Domain - CAHPS - Discharge Information (CMS View Applied)

100
75
50
25
0

May'19	Jun'19	Jul'19	Aug'19	Sep'19	Oct'19	Nov'19	Dec'19	Jan'20	Feb'20	Mar'20	Apr'20	May'20
n=182	n=158	n=134	n=149	n=140	n=136	n=159	n=141	n=141	n=156	n=127	n=45	n=7

NEXT STEPS & SUSTAINABILITY

- Collaborative Care Huddles as a hospital initiative led by hospital leader and physician leader continue to ensure that TeleTracking accountability continues
- Physician alignment is critical to ensure long term success
- Additional focus on patient experience and leadership rounding

SESSION RECAP

- Collaborative Care Initiative addressing hospital capacity management, inpatient care, discharge pre-planning and day of discharge activities reduced inpatient LOS and outlier LOS
- TeleTracking Tracking and Report Capabilities became critical enabling technologies to allow sustainable change in providing patient care at SRMH

SESSION SURVEY: YOUR OPINION MATTERS!

- Click on “RATE” or “RATE SESSION” for this session within the mobile or web app
- Complete the survey

Save the Date!

While we know TeleCon21 is more than a year away, we are excited because it is *TeleTracking's 30th Anniversary and we are already planning a spectacular event!*

We hope that you will make plans now to join us next year.

SAVE THE DATE

OCTOBER 17-20, 2021
JW MARRIOTT TURNBERRY MIAMI RESORT & SPA
AVENTURA, FL

https://telecon21.eventbrite.com

KNOWLEDGE BRIDGE

GET THE TELECON PRESENTATIONS

- Log in to **knowledgebridge.teletracking.com** for this and other TeleCon presentations
- Take the **Sys Admin and SynapseIQ® eLearning courses** for free
- Find the **mobile app** on the App Store or Google Play

TELECON20

Thank you

Leah Gehri, RN, MHA MN RN NEA-BC, Director
Santa Rosa Memorial Hospital
Leah.Gehri@stjoe.org

Michael Hill, MD, FACEP
President/CEO, MHMDAA
415.559.8616
Michael Hill MD and Associates
Michael.hill@mhmdaa.com
www.michaelhillmdandassociates.com