St. Luke's Hospital

Virtual Hospitalist Program
CHSHG Partnership

August 17, 2017

Exceptional care,
close to home

Mission

To provide quality, patient-focused health and wellness services.

Vision

To meet the changing needs of all we serve through safe, effective and compassionate care.

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History of SLH Hospitalist Program

- Pre-existing Hospitalist coverage
  - Issues with pre-existing coverage
- Existing Hospitalist buy-in
- Community physician buy-in and support
  (local primary care MD's - McCormack, Viar, others part-time coverage)
- Nursing Team "pain points" and process for buy-in/evaluation
- Perception of fragmented care

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CHSCHG Partnership for Care Delivery

- SLH was third CHS facility to go live with Virtual Hospitalist program
- Patient Experience – Compliments & Concerns – Survey Results
- Role of CHS-HG Team Support
  (monthly and regular communications)

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Clinical Care and Community Transition to Virtual Program

- Processes identified for patient care and clinical support
- Staff education and Mock events
- Focus on the Community – patient and family engagement
- General Patient Experience – Results
- Recent Program Improvements (Navigator role)

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Economic/Financial Benefits

- Cost of service
- Charge capture/revenue cycle
- Cost-benefit analysis (look-back)

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Benefits of Virtual Program on Quality and Patient Experience

- Real-time patient admissions/physician orders/documentation (H & P, etc.)
- Daytime Hospitalist benefits
  - Begin the shift with a clean slate (not playing catch-up)
  - Patients have care needs met without delays
  - Ability to hand-off patient concerns to following provider for on-going care
  - Increased job satisfaction
- Quality metrics embedded into program
- Excellent Patient Experience Scores
  - Consistently greater than 90th percentile.

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Impact on HCAHPS Scores

- Physician engagement in Patient Experience is a must
- Quality and Patient Experience results were built into physician compensation model
- Specifically, the HCAHPS domain of Communication with Doctors was established as an annual incentive goal
- Improved communication between virtual care physicians and daytime Hospitalists at end of shift hand-off has facilitated more timely care, better follow-up of care concerns and facilitates better patient throughput. Thus, improved patient experience.

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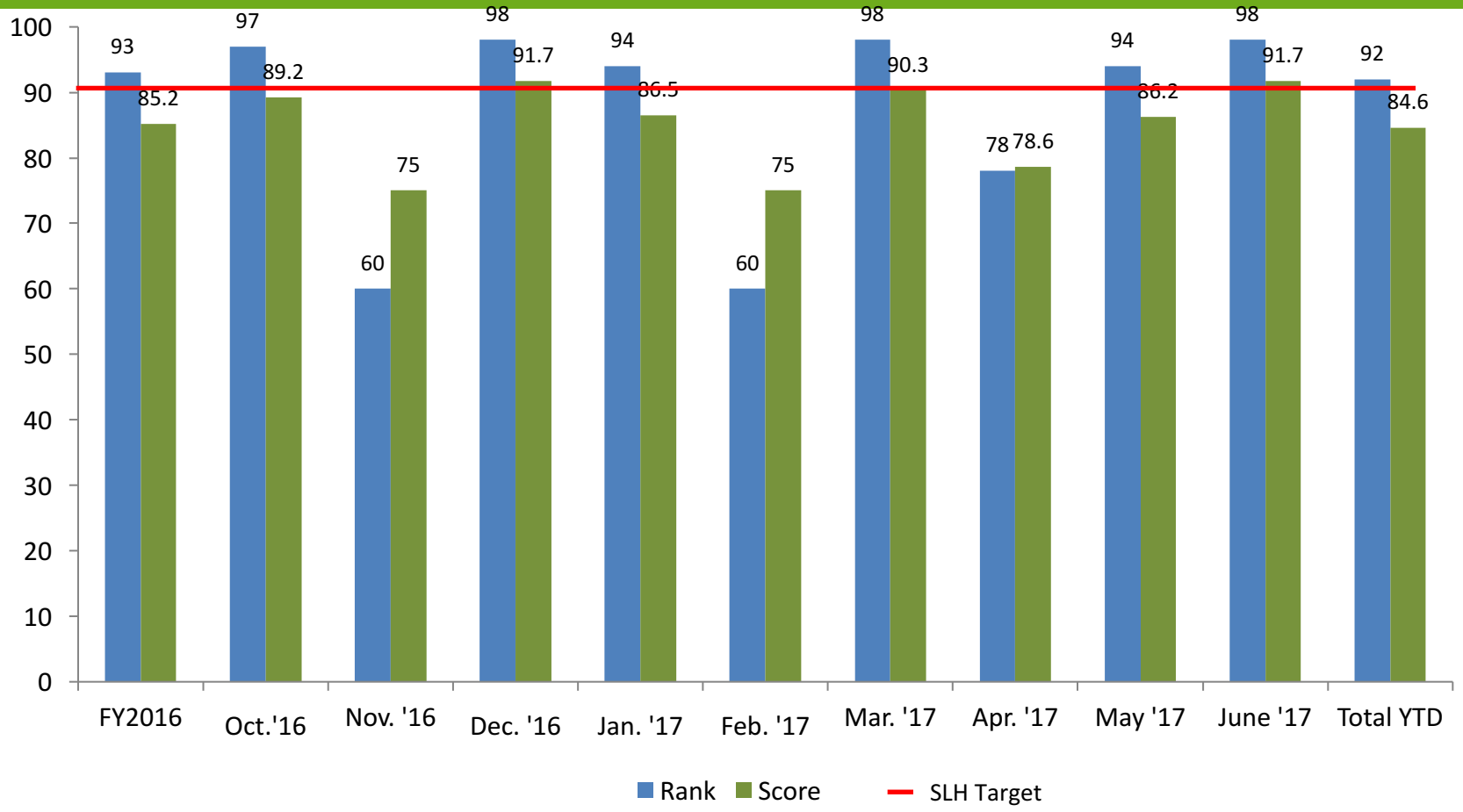
Inpatient Comparison
HCAHPS - Overall Rating
Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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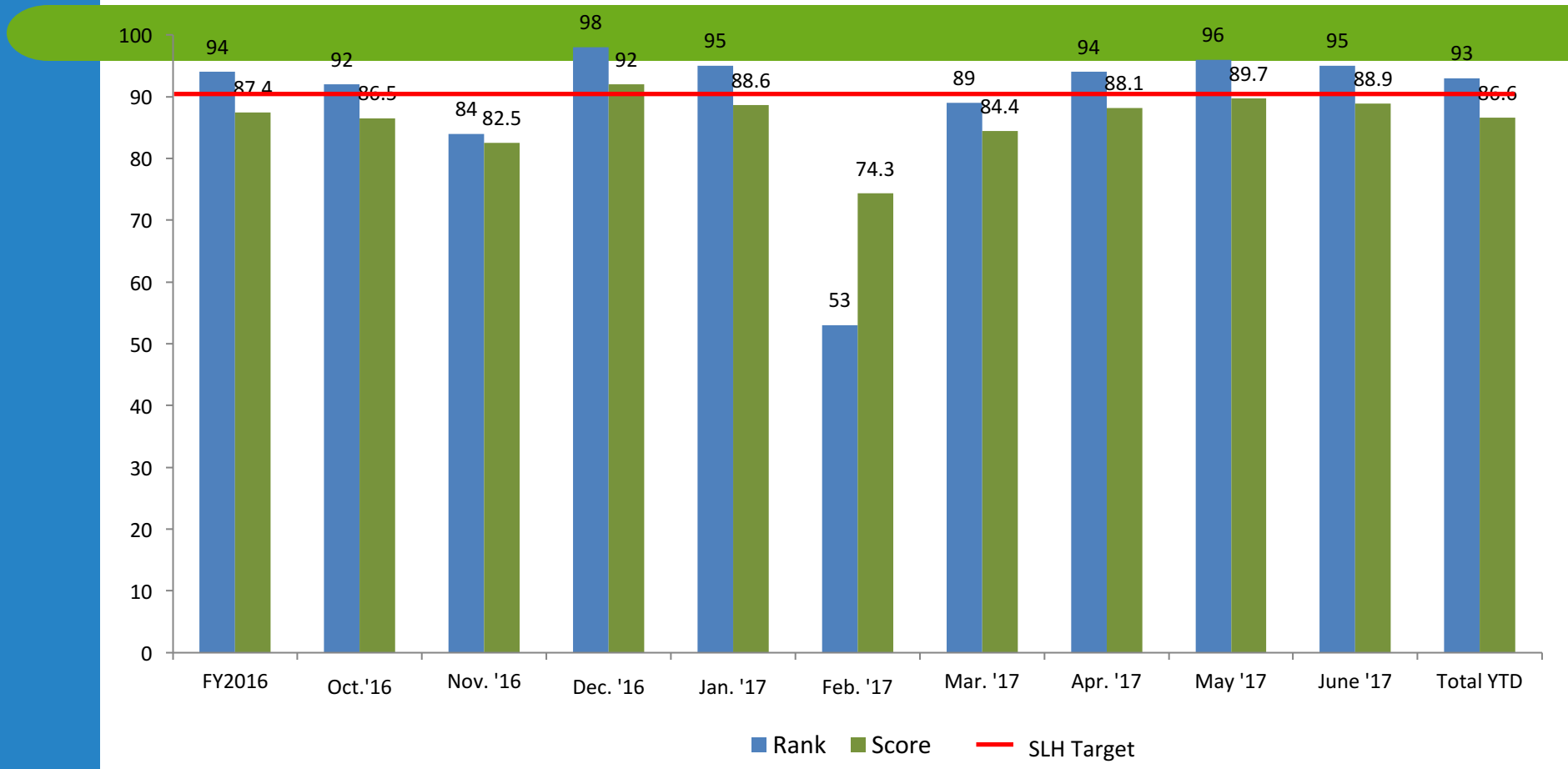
Inpatient Comparison
HCAHPS - Likelihood to Recommend
Percentile Rank puled by received date, adjusted, as of 7/11/2017



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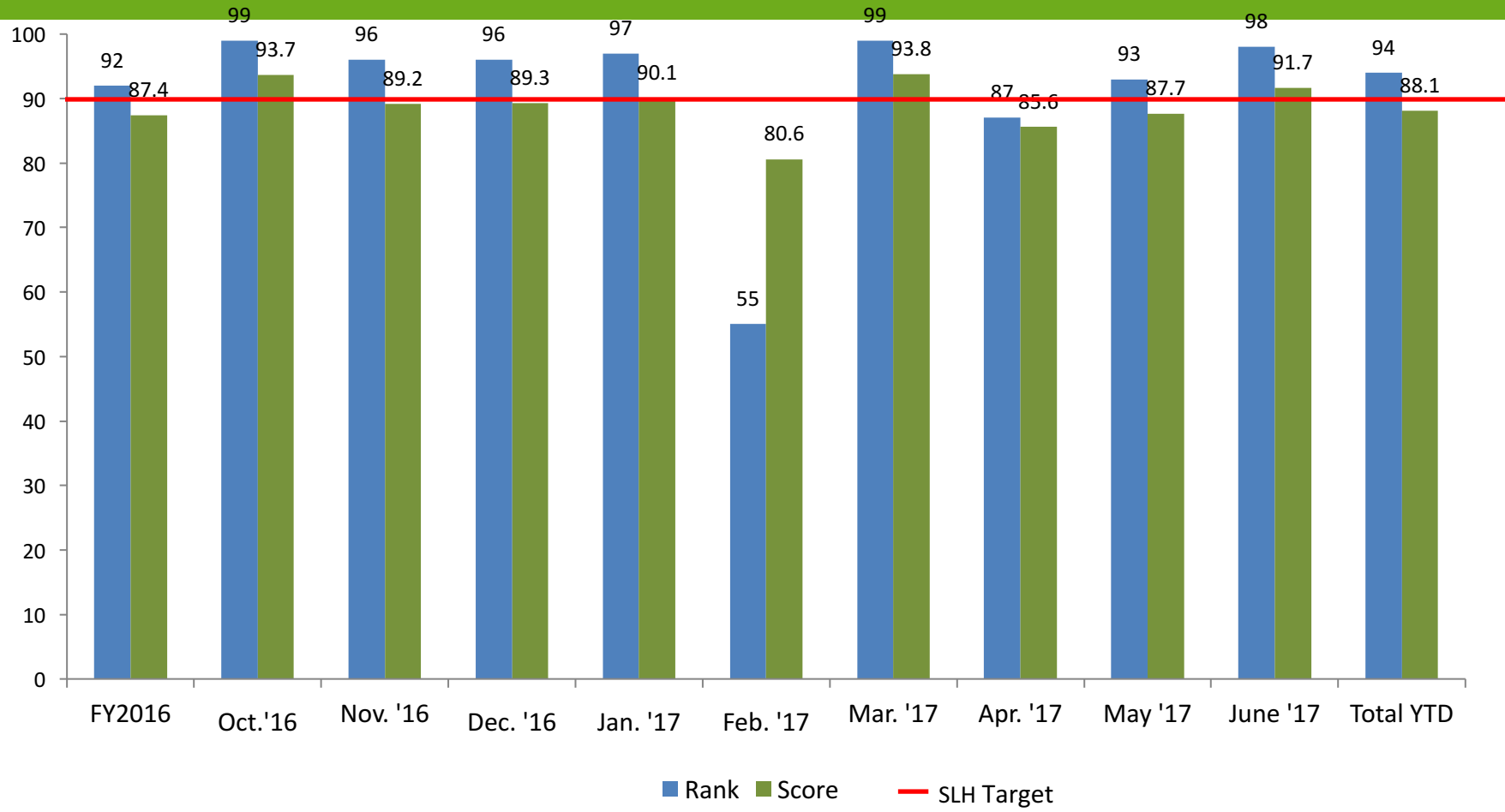
Inpatient Comparison
HCAHPS - Communication with Nurses
Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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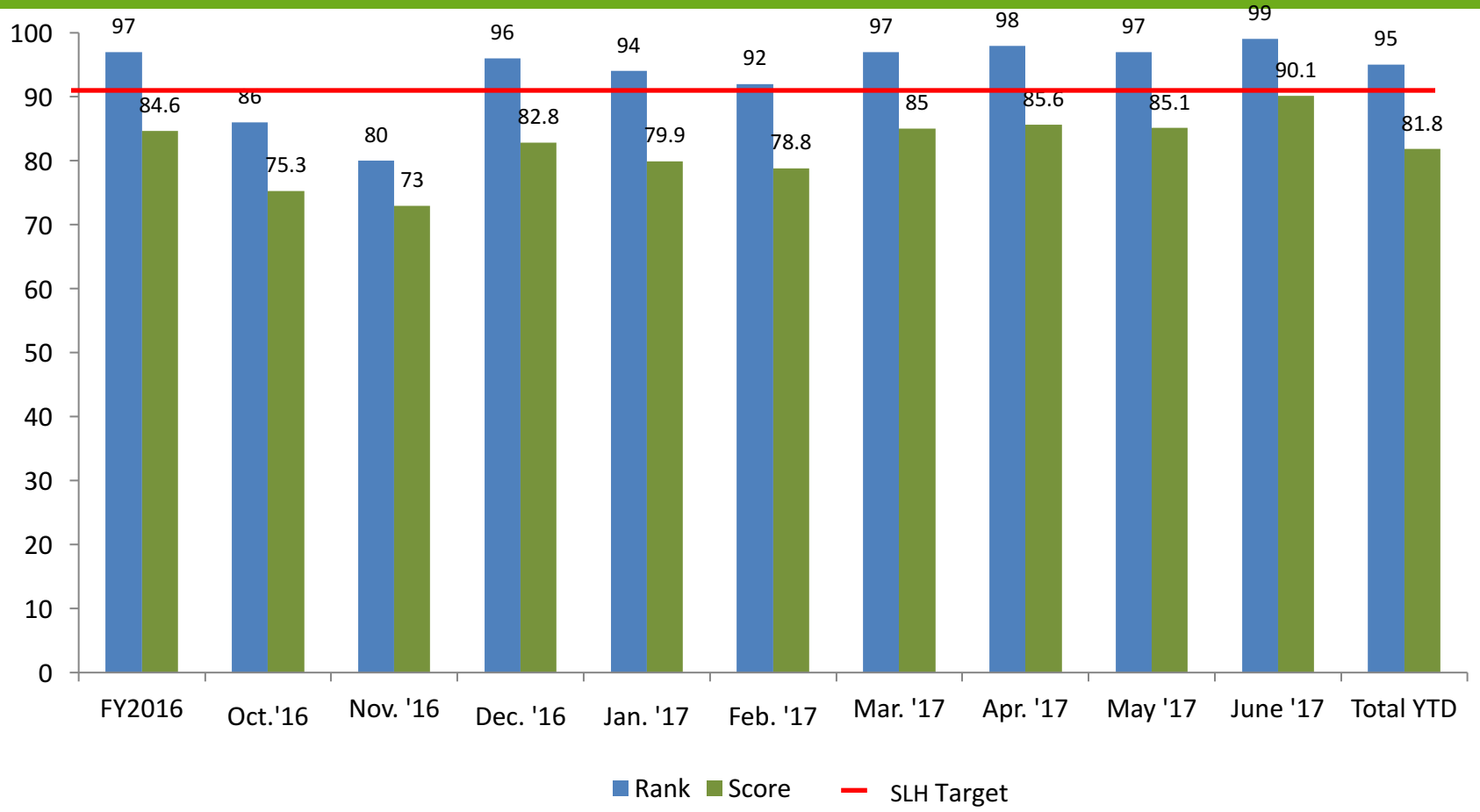
Inpatient Comparison

HCAHPS - Responsiveness of Hospital Staff

Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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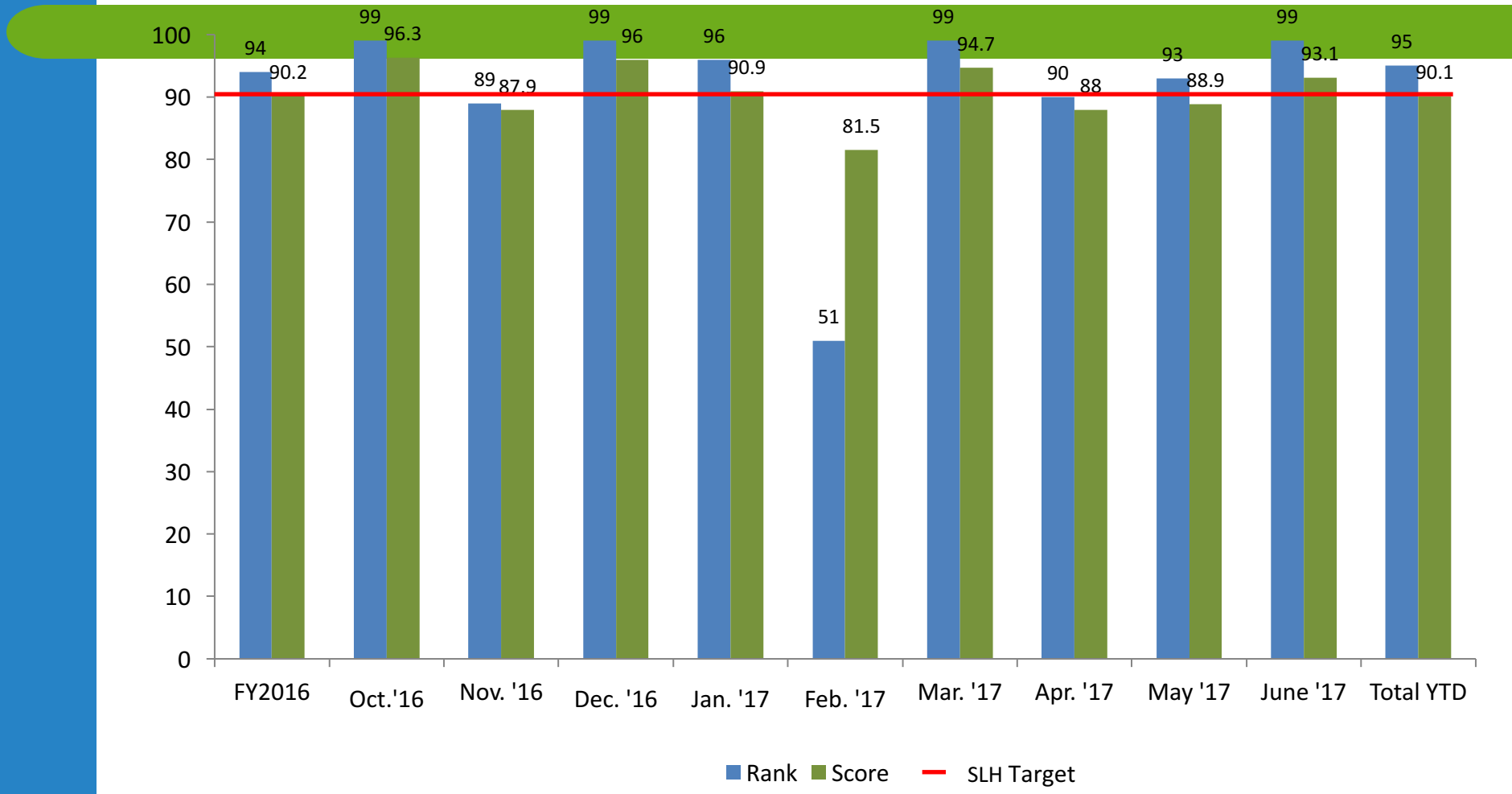
Inpatient Comparison
HCAHPS - Communication with Doctors
Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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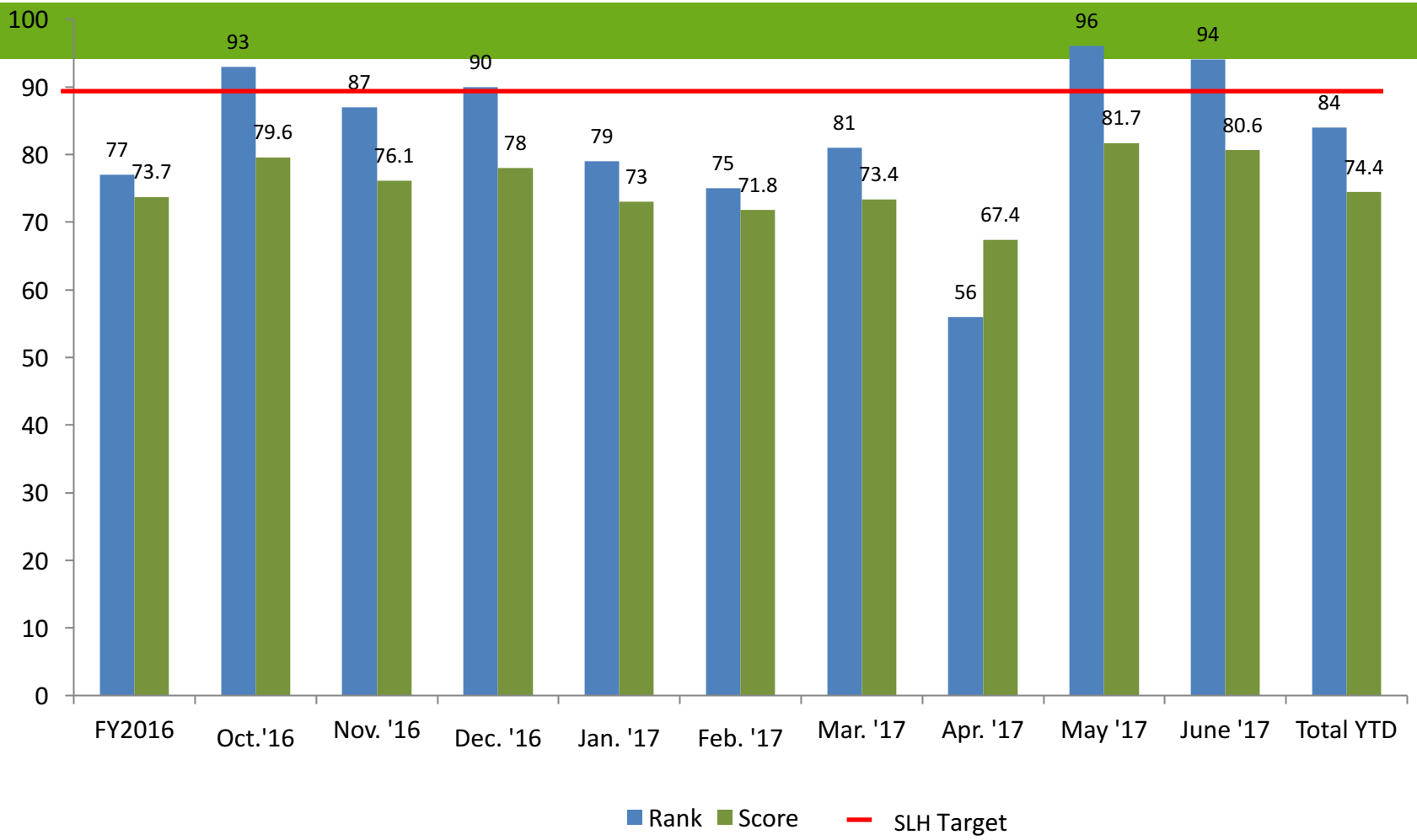
Inpatient Comparison
HCAHPS - Hospital Environment
Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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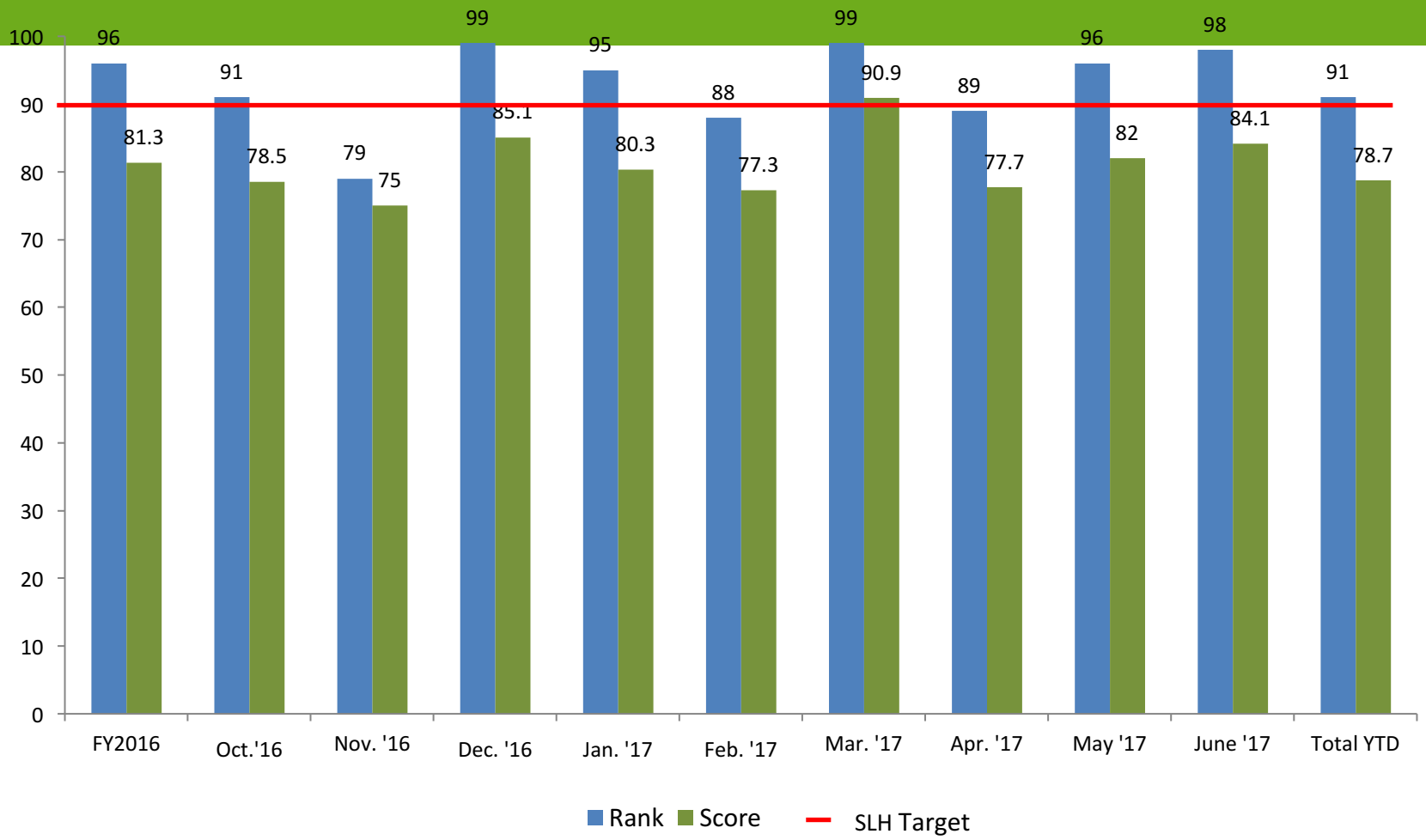
Inpatient Comparison
HCAHPS - Pain Management
Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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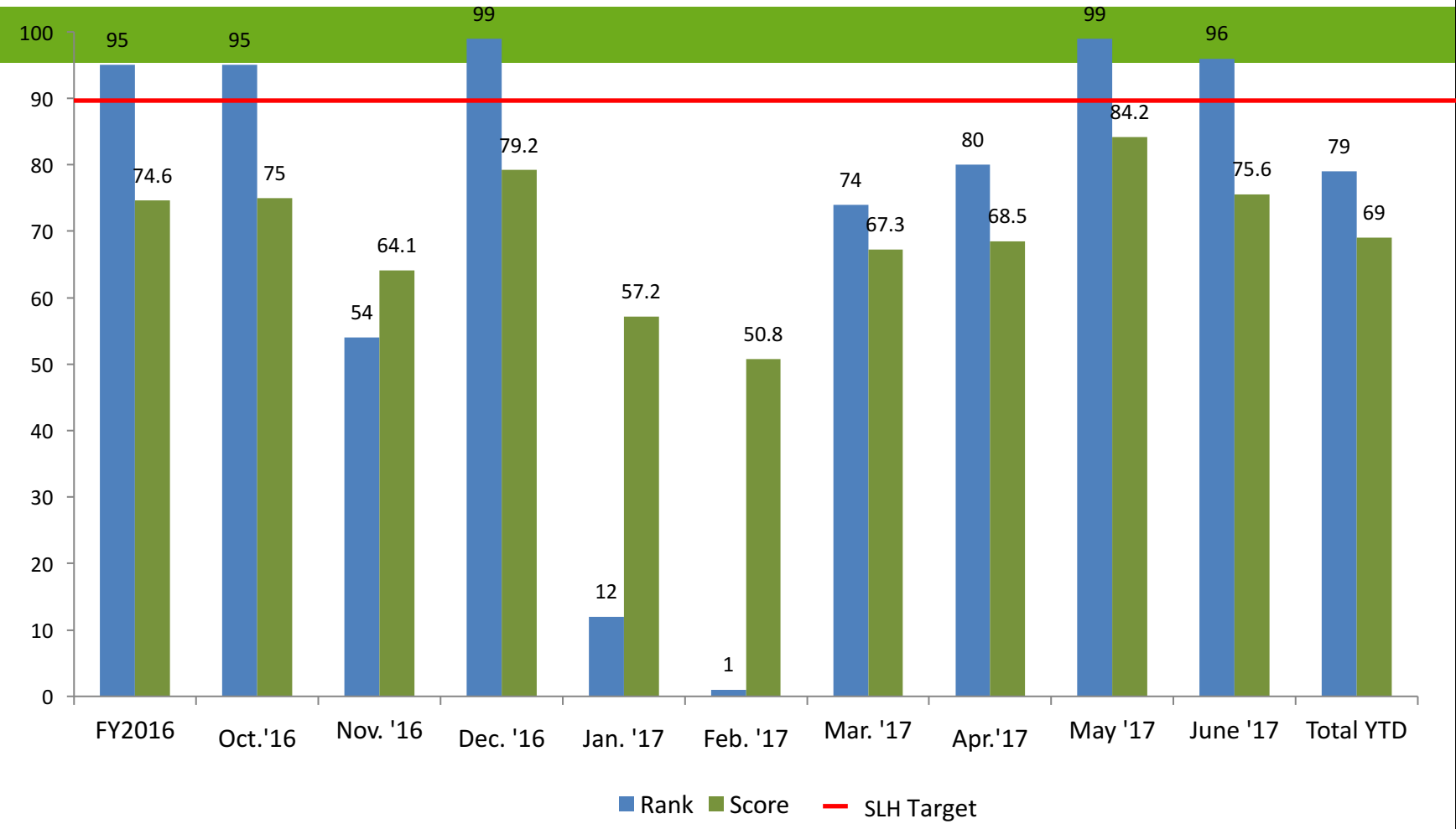
Inpatient Comparison
HCAHPS - Communication about Medicines
Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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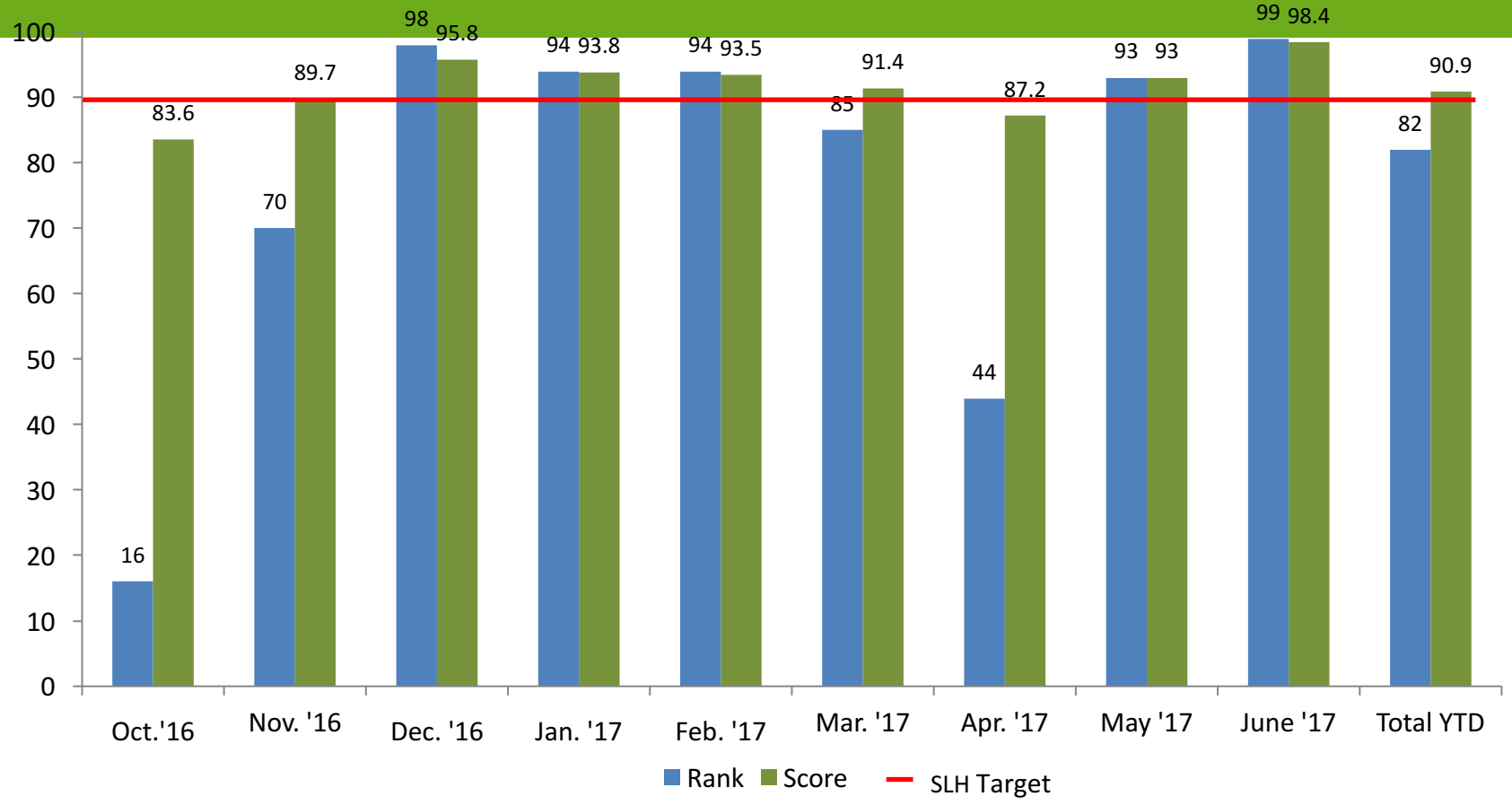
Inpatient Comparison
HCAHPS - Discharge Information
Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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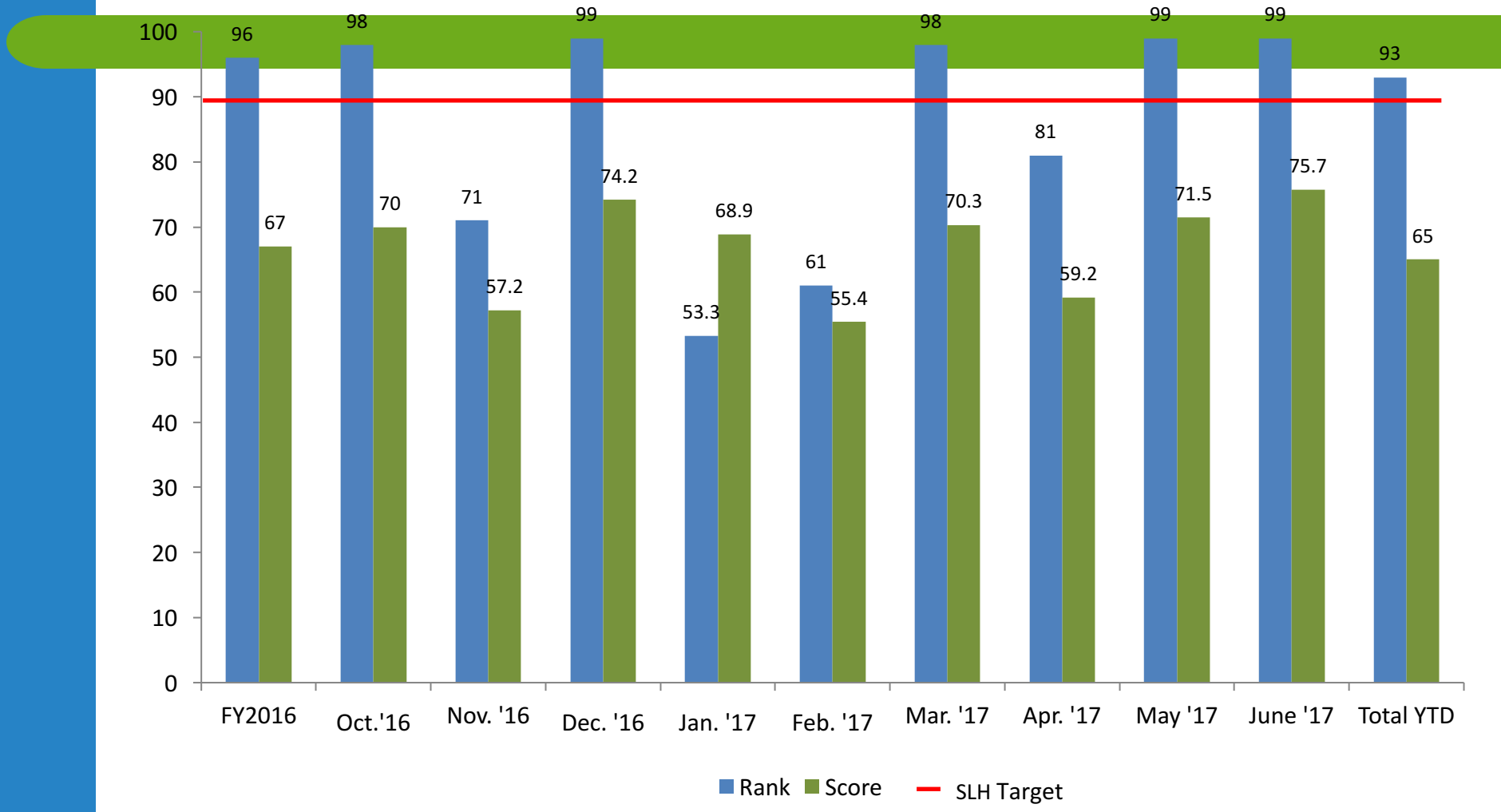
Inpatient Comparison
HCAHPS - Care Transition
Percentile Rank pulled by received date, adjusted, as of 7/11/2017



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Questions or Comments?

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HCAHPS Care Transitions

Tools for Success

- Morning Huddle- 8 am, 15-20 minutes
- Interdisciplinary Treatment (IDT) Rounds
- Discharge Planning Activities
- Joint Camp
- Transitional Care Community Case Manager
- Post-Discharge Phone Calls

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Morning Huddle: Plan for the Day

- Led by Hospitalist
  - Navigator, Supervisor, Discharge Planner, Case Manager, Ward Clerk
- Focus
  - Planned discharges, transition to swing-bed admission
  - Review of continued need for telemetry, foley catheters and planned transfers to lower level of care or out of facility transfers
  - Urgent, outstanding needs for new admissions

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Interdisciplinary Treatment Rounds

- 10:30 treatment team meeting
- All disciplines present
- Physician-led, all disciplines report
- Includes:
  - ADOD -Discharge Needs
  - Care needs -Nutritional status
  - Medication review -Rehab status
  - Antibiotic review -Standardized Form

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Discharge Planning Activities

- Participation in AM Huddle, IDT
- Standardized weekend calls to Nurse Supervisor for to review discharge needs
- Relationships with post-acute providers
- Facilitation of Regional Care Transitions Workgroup (previously by CCWNC)

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Discharge Planning cont'd

- Participation in Foothills Health Network and Community Partners Forum
- Partnership with Hospitalist RN Navigator
- CMS Discharge Planning Checklist now utilized for all admissions

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Joint Camp

- All elective joint cases participate in camp
- Led by Orthopedic Nurse Navigator
- Incorporates all service providers during camp for PPS needs
- First group to implement Discharge checklist
- Ensures that all post-hospital needs addressed pre-operatively

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Transitional Care Community Case Manager

- Case Manager hired May 2017
- Foothills Health Network Bridges
  - Group medical visit
  - High ED utilizers
  - Currently 6 enrolled
- Now following Hospitalist high risk referrals
  - Makes frequent calls to ensure compliance, identify potential issues
  - May accompany to office follow-up visits
- Will monitor impact on readmissions

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Post-Discharge Phone Calls

- Conducted by retired RN volunteer
- Real-time referrals to resources as needed
- Issues caught:
  - Access to medications
  - Follow-up appointments missing
  - Lack of response from post-acute providers
  - Care concerns- any issue reported to nursing supervisor immediately for follow-up

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Inpatient Comparison
HCAHPS - Care Transition
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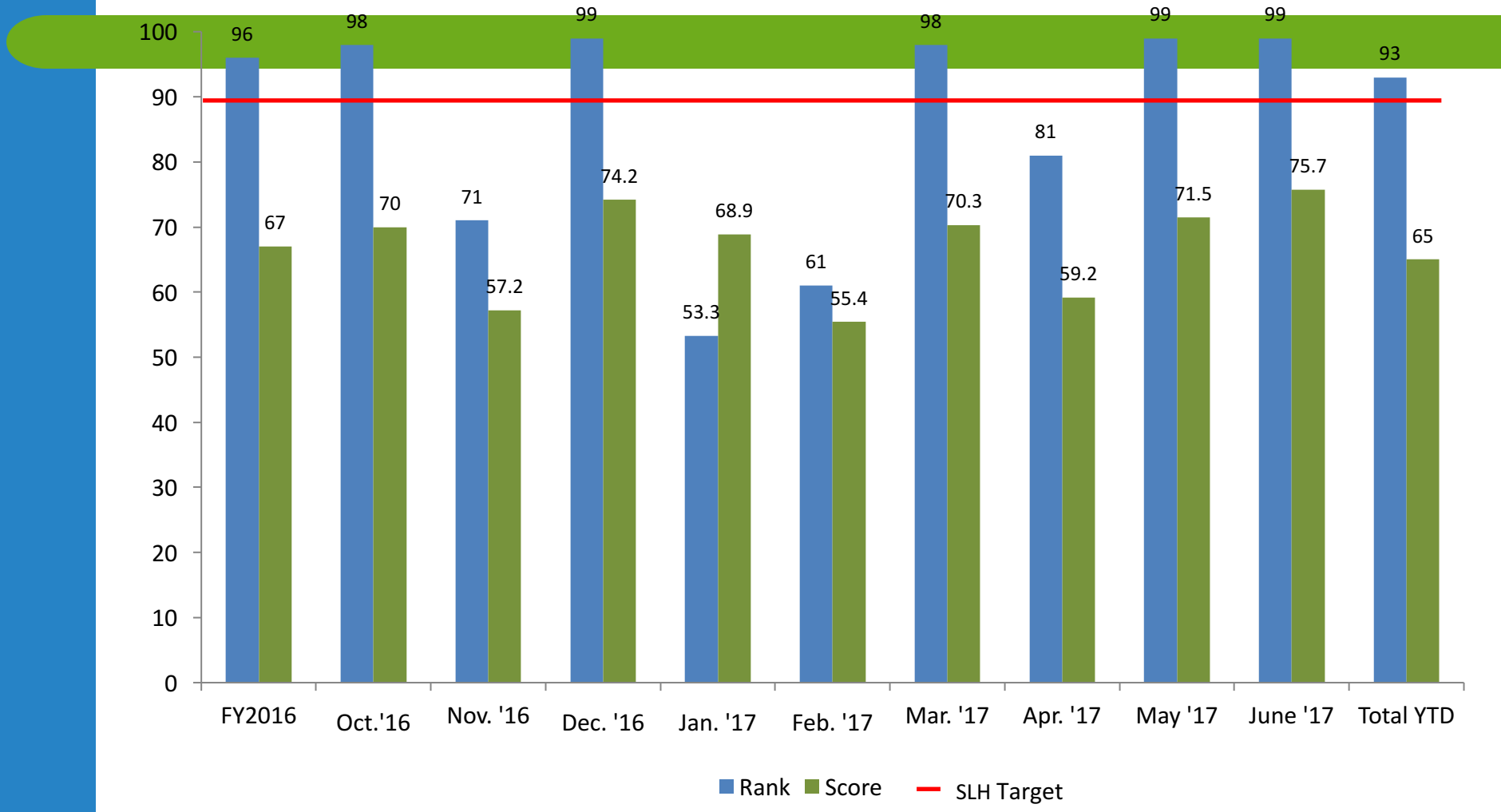

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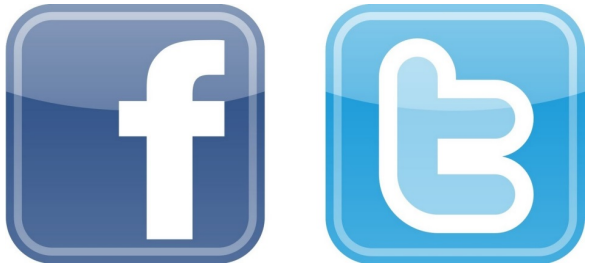

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