



VIZIENT CONNECTIONS SUMMIT

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THE POSSIBILITIES

vizient.



Performance Improvement Leaders Peer to Peer Education Meeting

Laural Whitmore, MSE, Vice President, Performance Improvement
Programs
Vizient

Overall Learning Objectives



- Discuss innovative strategies that effectively reduce hospital length of stay and improve patient outcomes.
- Describe how leveraging technology and interdisciplinary collaboration can streamline care coordination, minimize discharge delays and drive cost savings.

Disclosure of Financial Relationships



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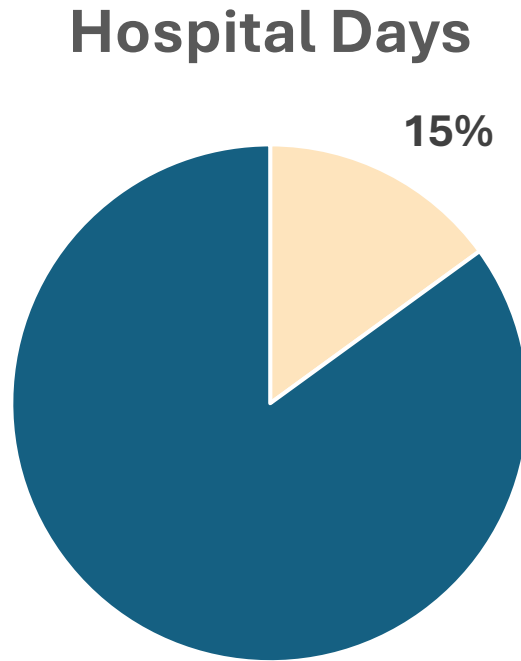
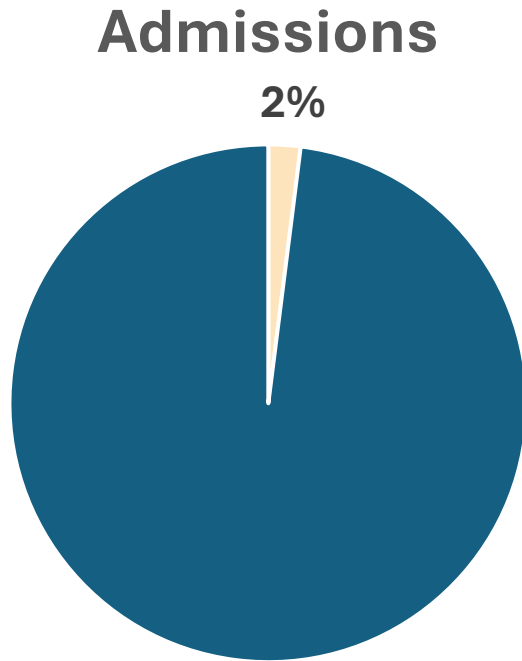


Performance Improvement Leaders Peer to Peer Education Meeting

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Vizient

Focus on Length of Stay

Prolonged hospital stays (>21 days)



Account for

\$2B

In annual cost¹

Direct costs =

\$2,093

per patient per
day²

1. Doctoroff, L, Hsu, DJ, Mukamal, K. Trends in prolonged hospitalizations in the United States from 2001 to 2012: A longitudinal cohort study. *Am J Med.* 2017;130(4):483.e.7. doi:10.1016/j.amjmed.2016.11.018.

2. Vizient Clinical Data Base. Length of stay direct costs based on calendar year 2024.

Readmissions & Mortality

risks **increase** for patients with
the longest stays ¹

Hospital occupancy
may exceed the

85%

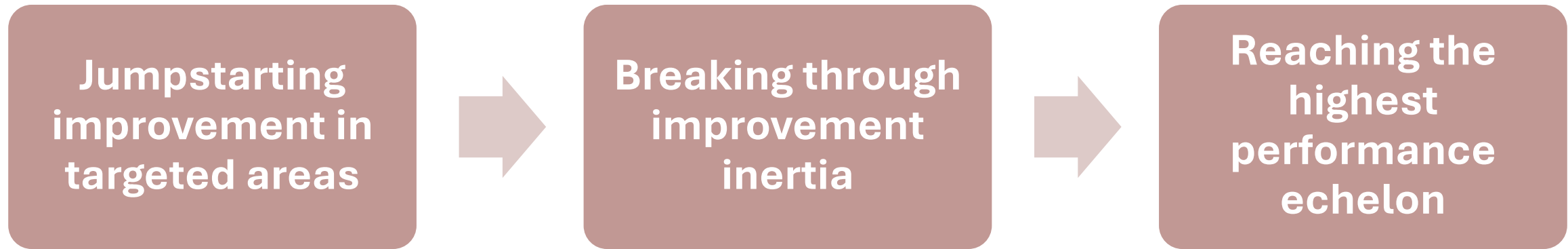
safety threshold by 2032²,
risking serious

delays in care



1. Han, TS, Murray, P, Robin, J, Wilkinson, P, Fluck, D, Fry CH. Evaluation of the association of length of stay in hospital and outcomes. *International Journal for Quality in Health Care*. 2022;34(2):1-9. doi:<https://doi.org/10.1093/intqhc/mzab160>.
2. Leuchter, R, Delarmente, BA, Vangala, S, Tsugawa, Y, Sarkisian, CA. Health care staffing shortages and potential national hospital bed shortage. *JAMA Network Open*. 2025;8(2):e2460645. doi:10.1001/jamanetworkopen.2024.60645

Performance Improvement As Your Strategic Engine



A Targeted Approach to LOS & Capacity



Developing an Actionable Capacity Plan Collaborative 2024-2025

Form a dedicated, cross-functional capacity team, define clear escalation triggers, and standardize daily discharge and communication practices to proactively manage hospital throughput.

High Reliability Culture of Safety Collaborative 2023

Build a high reliability culture by embedding leadership rounding, modeling personal accountability, and using structured huddles and debriefs to drive safety behaviors and team learning.

Reducing LOS to Improve Capacity Collaborative 2022-2023

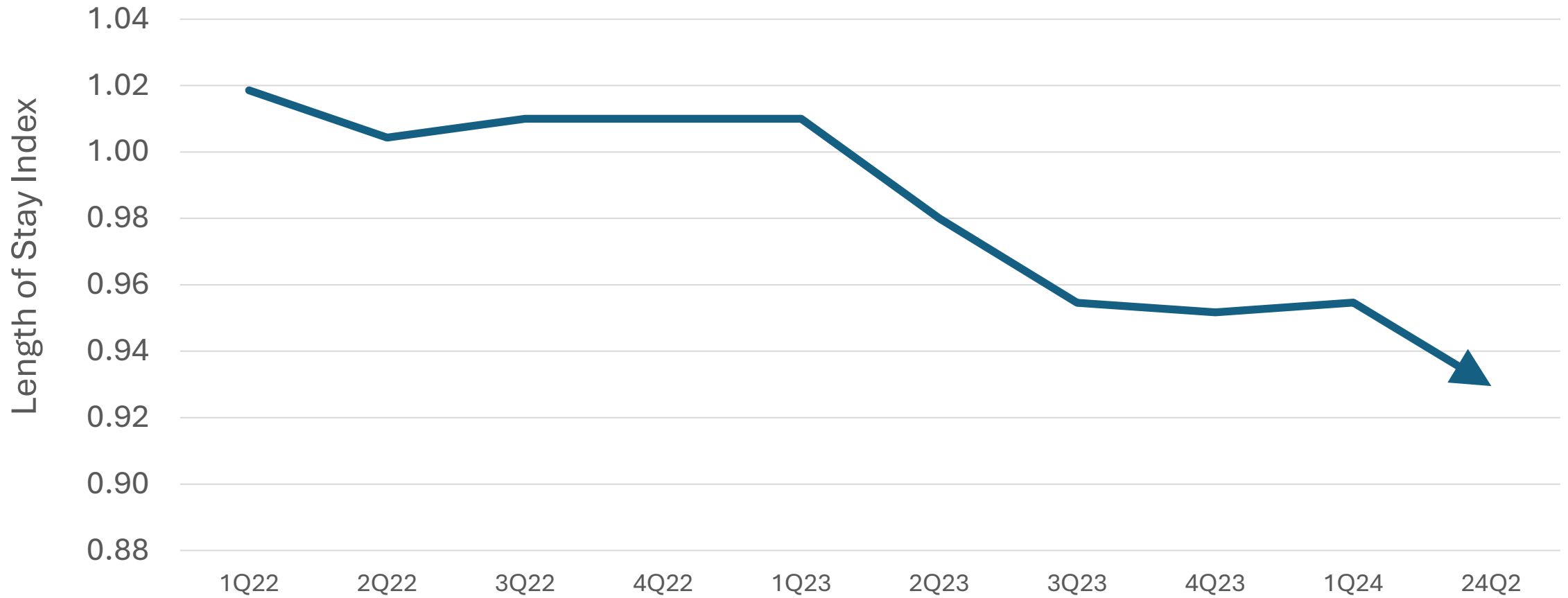
Reduce LOS by making discharge planning a day-one priority, using standardized interdisciplinary rounds, and leveraging real-time data and escalation pathways to resolve discharge delays early.

Creating a Culture of Mobility Collaborative 2022-2023

Improve patient outcomes by embedding mobility into daily workflows—use standard assessments, interdisciplinary planning, and mobility champions to drive safe, early, and consistent movement.

LOS index since 2022

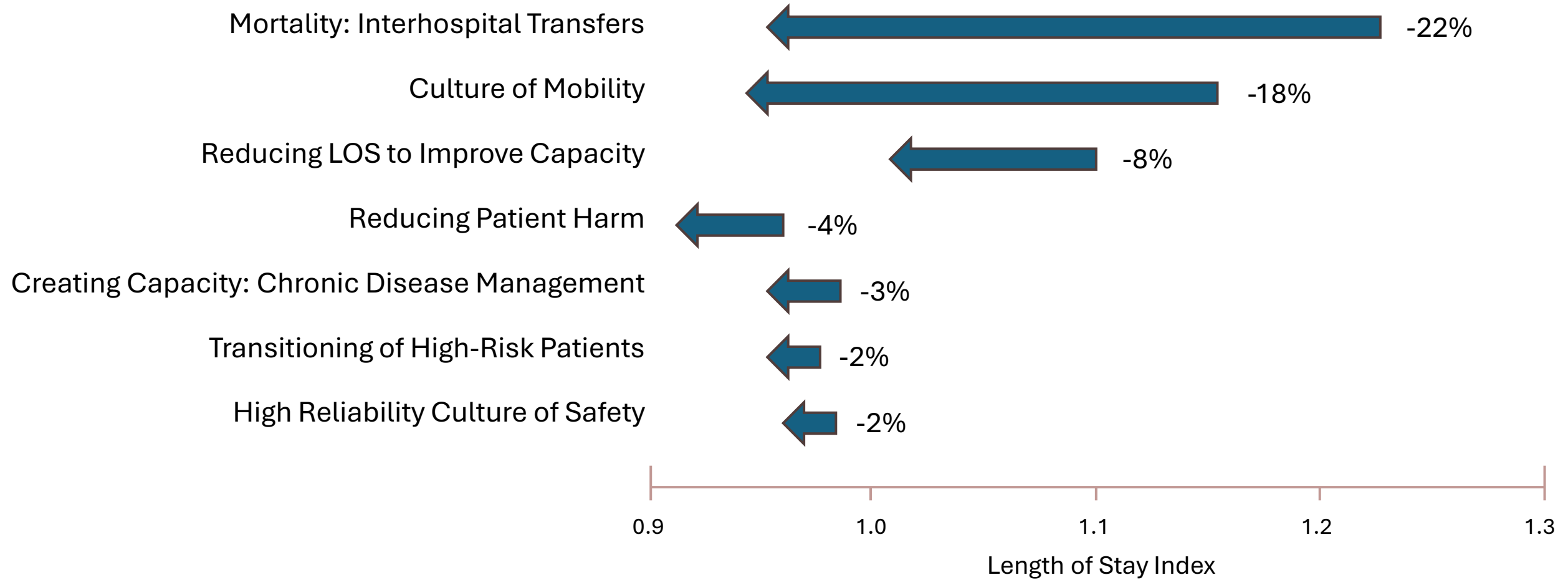
Member Networks PI Program Members



Data Source: Internal Vizient CDB.

n=644

Project impact on inpatient length of stay



Data Source: Internal Vizient CDB.

Outcomes that matter



2024 Results:

- \$750M – 2024 total Vizient Member Networks member value
- 1,196 – Readmissions avoided in the Chronic Disease Management Collaborative
- 73,740 – Inpatient days avoided in the Establishing a Structured Sepsis Performance Improvement Team Collaborative

Make this meeting count!



- Ask questions during the sessions to clarify feasibility and impact
- Connect with peers during the break to share ideas and build collaborative relationships
- Reflect on how your current capacity challenges align with the improvement tactics presented
- Capture key takeaways and potential next steps to bring back to your team
- Be ready to participate in live polls using your phone to share input, just scan the QR code when prompted and let your voice be heard



From Assumptions to Evidence: Insights from the Vizient Length of Stay Breakthrough Survey

Laura Hoffman, DNP, MSN, RN, CPHQ, Senior PI Program Director

**Eric Lam, Principal, Intelligence
Vizient**

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Learning Objectives



- Identify emerging capacity-related strategies and assess strategies with the strongest correlation to shorter lengths of stay (LOS).
- Understand how to create a case for change to secure executive commitment and implement data-driven strategies to reduce LOS.

Length of Stay (LOS) Breakthrough Survey goals



By the end of this project, participants will:

Gain a broader understanding of your organization's strategies and impact on LOS

Benchmark your current state alongside other Vizient members

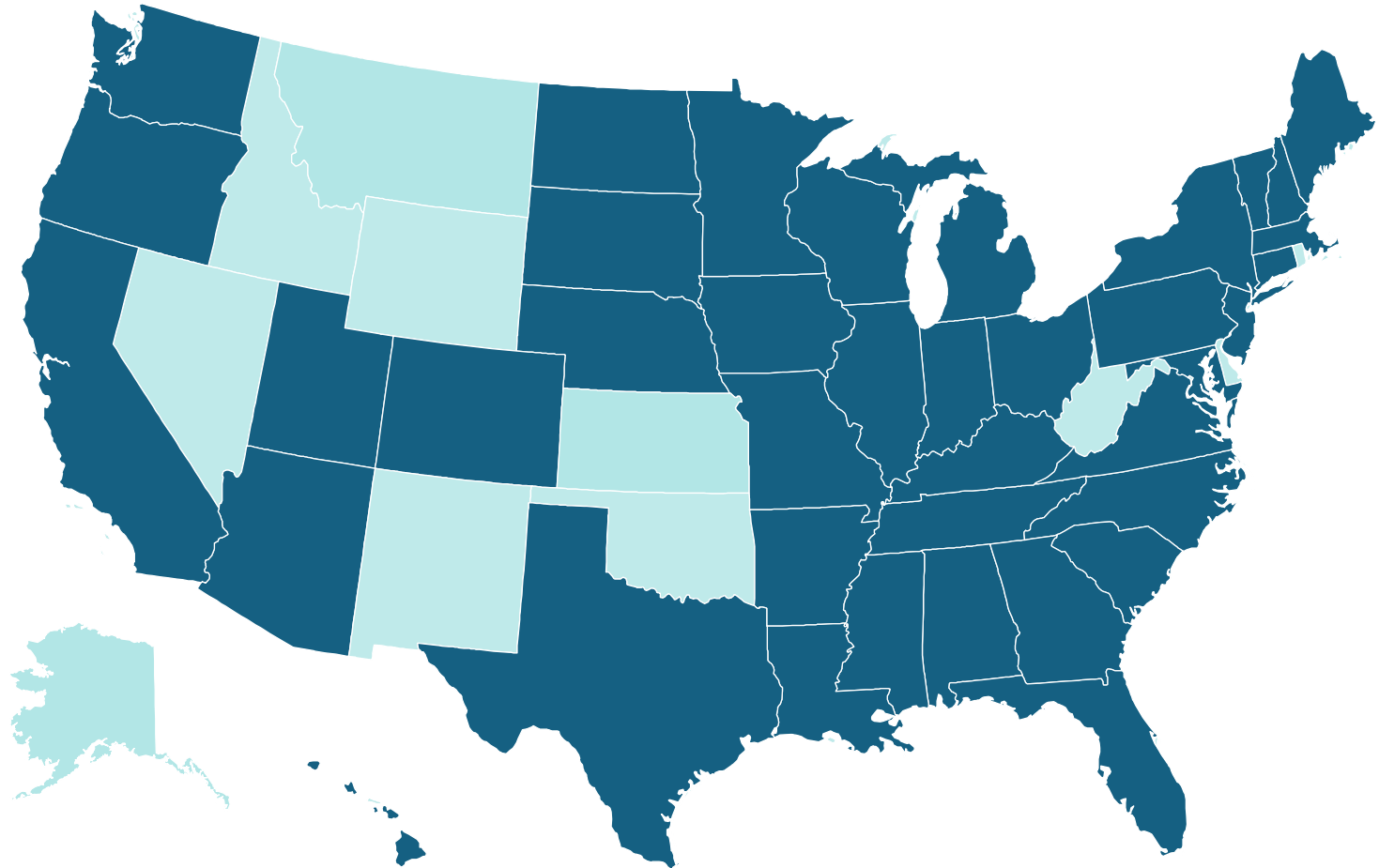
Identify and share emerging practices in LOS strategies that have the highest impact

Move from assumptions to data-driven decisions to decrease LOS

Benchmarking survey participants by state

168 hospitals
representing 39
states*

**Participants are denoted by the
darker blue*



How do we know what strategies are most effective? And at what level?



Reduction strategy	Reduction strategy
Standardized escalation for non-clinical delays	Patient rounding practices
Early discharge task completion	Data-driven discharge optimization
Capacity planning and management	Dedicated observation unit utilization
Addressing vulnerable high-risk patients	Observation unit utilization throughout the hospital
Addressing social needs	Palliative care integrations
Skilled nursing facility (SNF) collaboration	Identification of high-risk patients
Long LOS management	Weekend staffing adjustments

LOS breakthrough survey question example



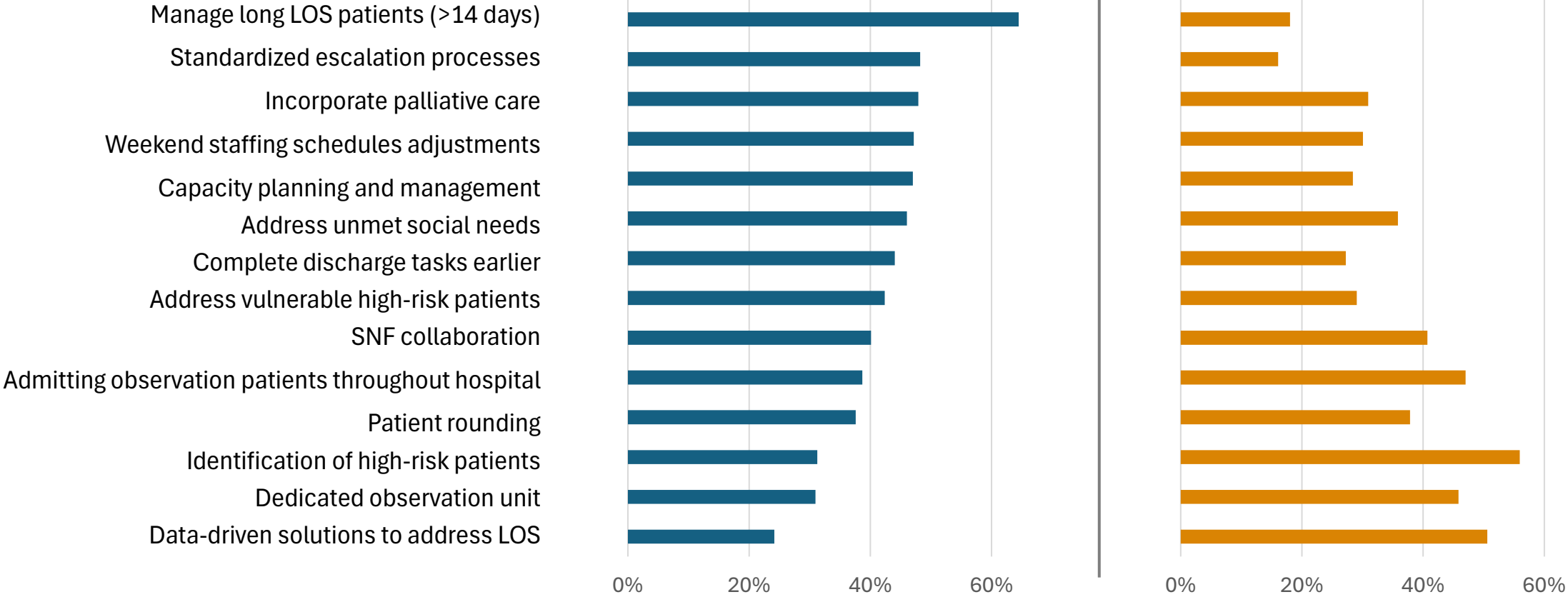
Question	Improvement Strategies	No, not implemented	Implemented up to 25%	Implemented up to 50%	Implemented up to 75%	Fully implemented
1	Indicate if you have implemented a standardized escalation process to address non-clinical discharge delays.					
2	Indicate which processes you have implemented to complete discharge tasks earlier in the patient's stay.					
	a. Structured discharge checklist					
	a. Electronic medical record (EMR) based discharge planning tools					
	a. Dedicated discharge planning staff					
	a. Rebalancing of discharge tasks to earlier in the patient's stay					
3	Indicate whether these strategies are used for capacity planning and management.					
	a. Real-time capacity plan					
	a. Real-time bed tracking					
	a. Predictive admission/discharge analytics					
	a. Automated bed assignment					
	a. Capacity dashboard visible to all stakeholders					
	a. Defined capacity escalation triggers					
a. Assigned accountability for each capacity trigger						

Organizational LOS Strategies Implementation



High Implementation *>75% Implemented Across Organization*

Low Implementation *<25% Implemented Across Organization*



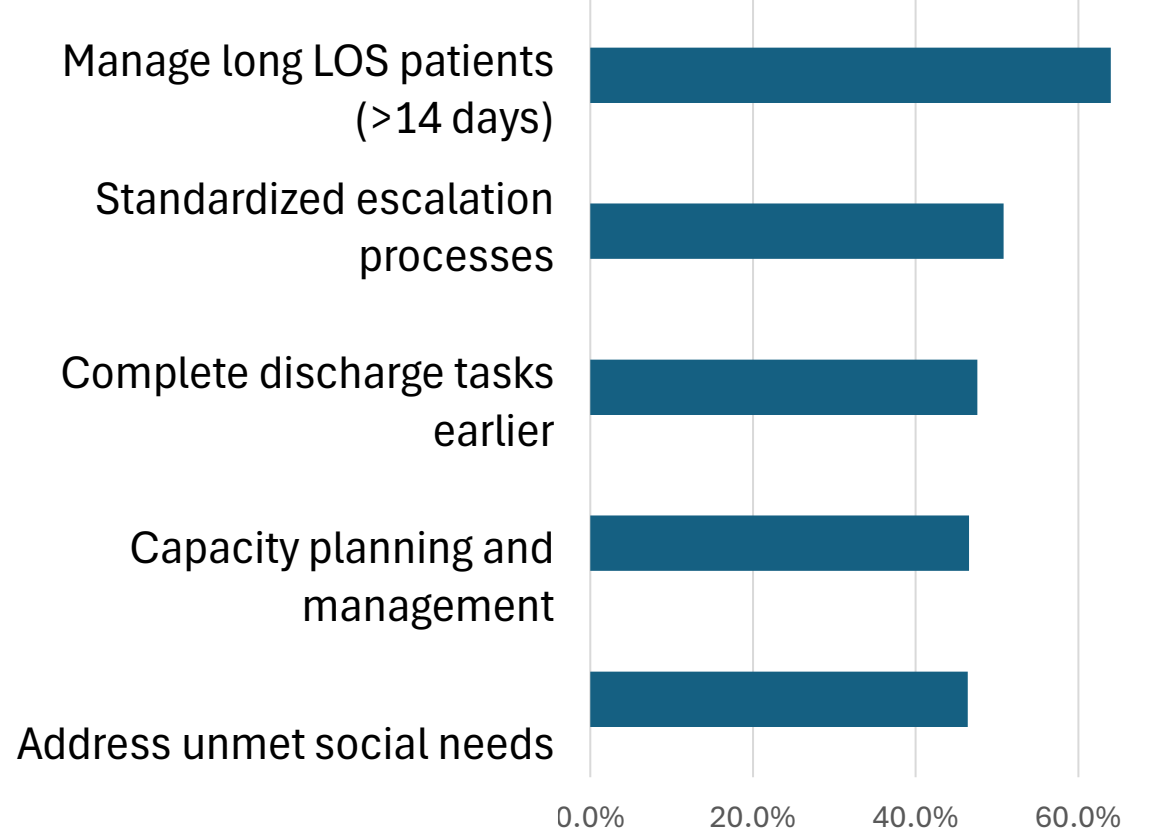
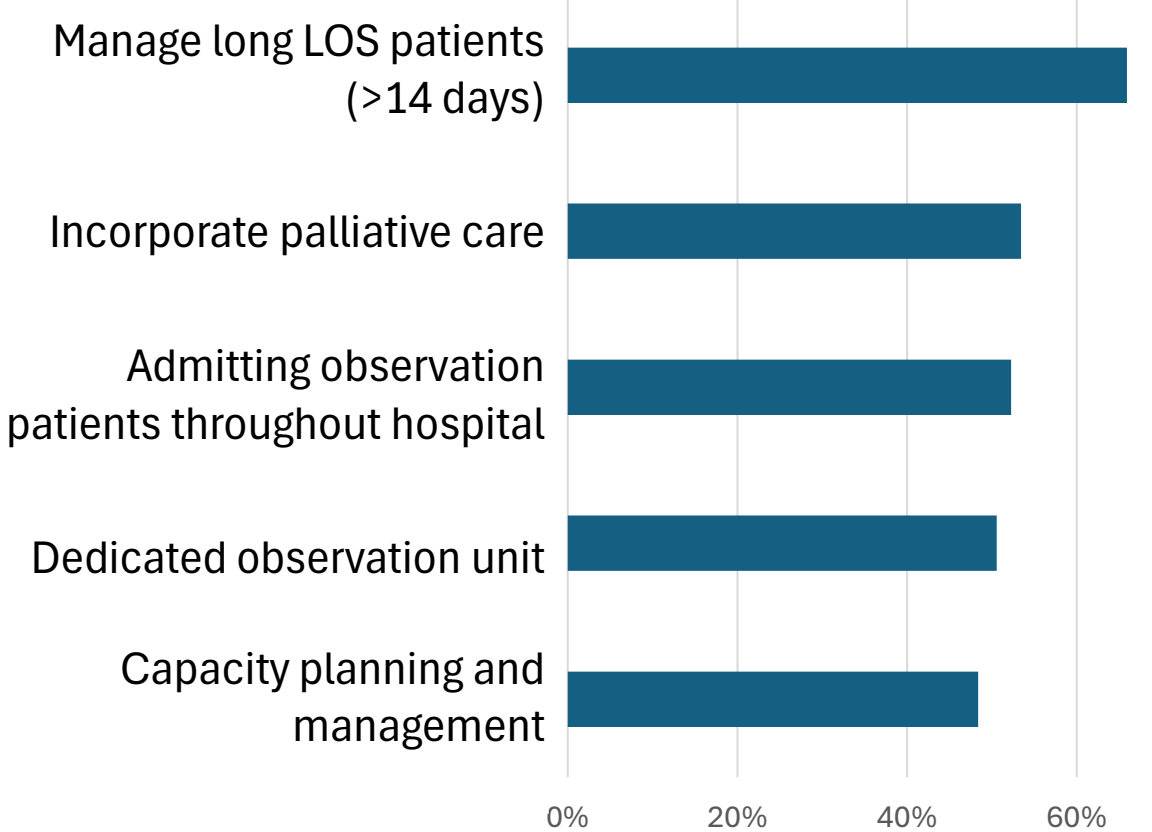
Data from Vizient Member Networks PI Programs Length of Stay Breakthrough Survey used with permission of Vizient, Inc. All rights reserved.

High Implementation LOS Strategies by Hospital Cohort



AMCs

Community Hospitals



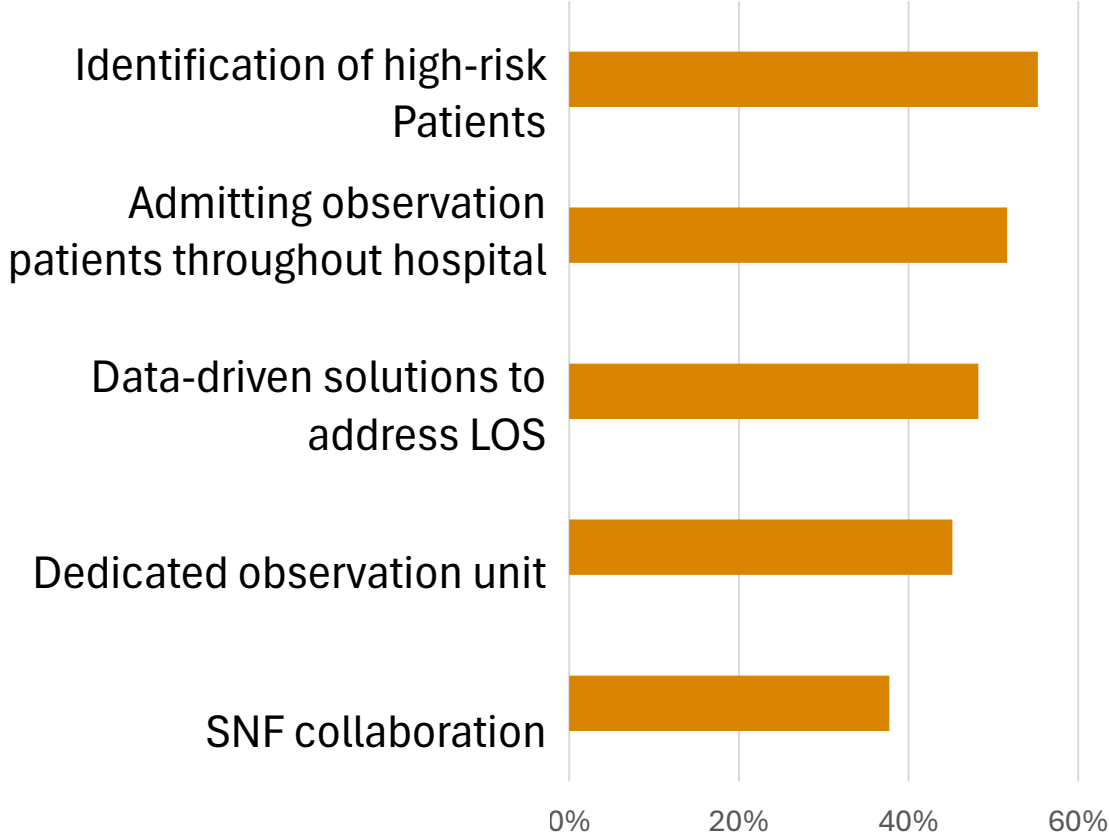
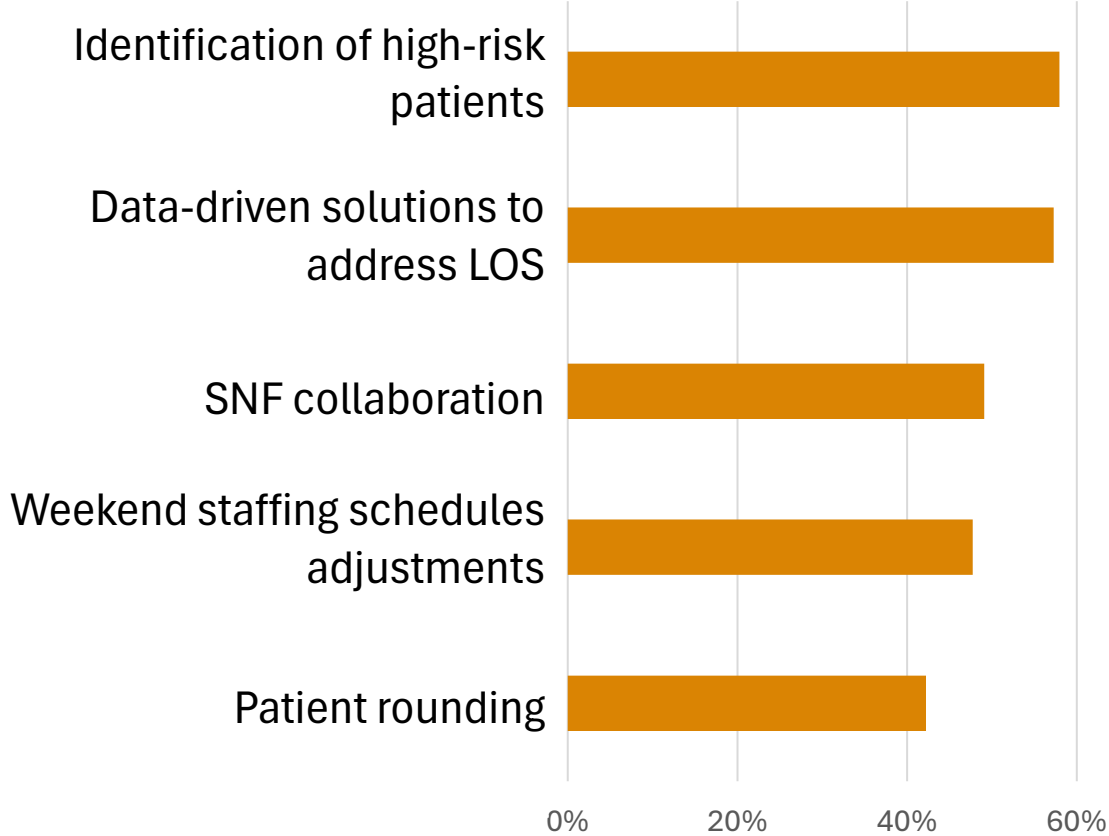
Top 5 LOS strategies based on >75% implementation across organization for all organization types.
 Data from Vizient Member Networks PI Programs Length of Stay Breakthrough Survey used with permission of Vizient, Inc. All rights reserved.

Low Implementation LOS Strategies by Hospital Cohort



AMCs

Community Hospitals



Top 5 LOS strategies based on <25% implementation across organization for all organization types.
 Data from Vizient Member Networks PI Programs Length of Stay Breakthrough Survey used with permission of Vizient, Inc. All rights reserved.

LOS Reduction Strategies Correlation with Outcomes



LOS Index Correlation

LOS Reduction Strategy	LOS Index Correlation		
	Overall	AMC	Non-AMCs
Standardized escalation processes	r = 0.31 p = <0.001		r = 0.33 p = <0.001
Address unmet social needs		r = 0.42 p = 0.005	
Address vulnerable high-risk patients	r = 0.24 p = 0.004		r = 0.20 p = 0.048
Identification of high-risk patients		r = 0.31 p = 0.043	

Correlation Strength

- Strong
- Moderate
- Low or None

r = Pearson correlational coefficient. p = statistical significance. Strategies with low or no correlation excluded from slide. LOS index from Vizient Clinical Data Base, used with permission of Vizient, Inc. All rights reserved.. Accessed August 2025. LOS index = observed LOS/expected LOS. Data from Vizient Member Networks PI Programs Length of Stay Breakthrough Survey used with permission of Vizient, Inc. All rights reserved.

Create your LOS case for change



- **Prioritize strategies with higher impact on LOS performance:**
 - **Proactive identification of high-risk patients:** Leverage predictive models or screening tools to identify patients with high potential for extended LOS due to risk of complications, medical complexity or functional status and develop protocols to address.
 - **Data-driven interventions:** Use performance metrics and clinical analytics to guide targeted actions and track impact over time.
 - **Standardize the escalation process:** Identify contributing factors to discharge delays and raise awareness up the chain of command so the right people can act sooner.
- **Prioritize opportunities for improvement:** Analyze performance across prioritized strategies to pinpoint departments or patient populations with the greatest potential for impact.

Lessons Learned



- **Systemwide Consistency Is Critical:** While LOS (Length of Stay) strategies may be in place, variability in implementation across departments can dilute overall impact. A coordinated, hospital-wide approach is essential for meaningful results.
- **Leverage Proven Tactics Across the System:** Significant variation exists not only within individual hospitals but also across facilities within the same health system. Identifying high-performing strategies and scaling them systemwide enhances consistency and accelerates improvement.
- **Focus on Depth Over Breadth:** Given resource constraints, organizations should prioritize deeper implementation of fewer, high-impact strategies rather than spreading efforts thinly across many partially-adopted initiatives.
- **Tailor Strategies to Organizational Context:** The potential impact of LOS interventions varies based on factors such as patient acuity, service lines, volume, and geographic reach. Aligning initiatives with organizational identity and population needs ensures strategic fit and operational relevance.

Key Takeaways

- Identify the top 2 strategies that impact LOS outcome metrics and assess your organization's level of implementation.
- Utilize a prioritization matrix to determine which strategy (or strategies) to implement.
- Complete an implementation plan to outline action steps, assign a single point of accountability and establish a timeline for completion.
- Start small. Consider piloting changes in one hospital or within a select few service areas. Perform tests of change to uncover what works best before implementing system-wide.

Questions?



Contact:

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Eric Lam, eric.lam@vizientinc.com

This educational session is made possible through the collaboration of Vizient Member Networks.

Appendix

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THE POSSIBILITIES

How do we know what strategies are most effective? And at what level?



Reduction strategy	Brief description
Standardized escalation for non-clinical delays	Clear processes for resolving discharge barriers unrelated to medical readiness
Early discharge task completion	Includes discharge checklists, electronic medical record tools and rebalancing task timing
Capacity planning and management	Real-time tools: bed tracking, dashboard, predictive analytics
Addressing vulnerable high-risk patients	Transition coordinators, follow-up programs and complex care teams
Addressing social needs	Housing, transportation, financial aid and food access programs
Skilled nursing facility (SNF) collaboration	Formal/informal agreements and guardianship process support
Long LOS management	Dedicated committees and case managers for long LOS
Patient rounding practices	Bedside, interdisciplinary and leadership-specific rounding formats
Data-driven discharge optimization	Artificial intelligence scoring, discharge forecasts and barrier tracking
Observation unit utilization	Existence and use of dedicated observation units
Palliative care integrations	Dedicated teams and consults in the emergency department or high-risk scenarios
Identification of high-risk patients	Automated screening tools and clinician assessments
Weekend staffing adjustments	Scheduling improvements across hospitalists, nurses, case managers and ancillary staff



SSMHealth.

Saint Louis University Hospital



Escalating Your Escalation Game: A Lean, HRO Approach

Thomas Conte, LSSGB, Operations Coordinator

Adam Fritz, MD, MSHA, FACP, Associate Chief Medical Officer

SSM Health Saint Louis University Hospital

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Learning Objectives



- Discuss the methods used to create a novel discharge barrier escalation pathway while leveraging lean and HRO principles.
- Quantify the effects of streamlining discharge barrier escalations on key performance indicators, such as Length of Stay and Excess Days.

SSM Health System Overview



SSMHealth.



SSM Health was founded in 1872 by the Sisters of St. Mary



11.4B Not-for-Profit Catholic Health System



Multi-State Health System operating in Missouri, Illinois, Oklahoma, and Wisconsin



\$406M
Community Benefit



20 Managed Hospitals/Affiliate Relationships



40,000
Team Members



490+ Physician Office/Outpatient Sites



15,000
Physicians/Providers



17.7M Members Across 50 States – Navitus PBM



23
Hospitals



58 Counties Served by SSM Health at Home



9
Post Acute Facilities



234,979
Virtual Visits in 2024

Data Source: Internal SSM Health System Presentation

SSM Health Saint Louis University Hospital



SSMHealth.

Saint Louis University Hospital



American College of Surgeons Level 1 Trauma Center



Level 1 Time Critical Care Diagnosis STEMI Center – MO
Department of Health & Senior Services



Level 1 Time Critical Care Diagnosis Stroke Center – MO
Department of Health & Senior Services



Midtown St. Louis, MO



Academic Medical Center



438 Licensed Beds



21 Operating Rooms



NAPBC Breast Center Accreditation



Center for Outpatient Blood and Marrow Transplant



Designated Level 4 Epilepsy Center (NAEC)



Center for Abdominal Transplant



CoC Accredited Cancer Program



ACPE Accredited Pastoral Care Program

SSM Health Saint Louis University Hospital



Data Source: Internal SSM Health Dashboard, 2025 Mid-Year Annualized Data

SSM Health Saint Louis University Hospital



20.7%

of distinct patients from a neighborhood with a Vizient Vulnerability Index >1

24.16%

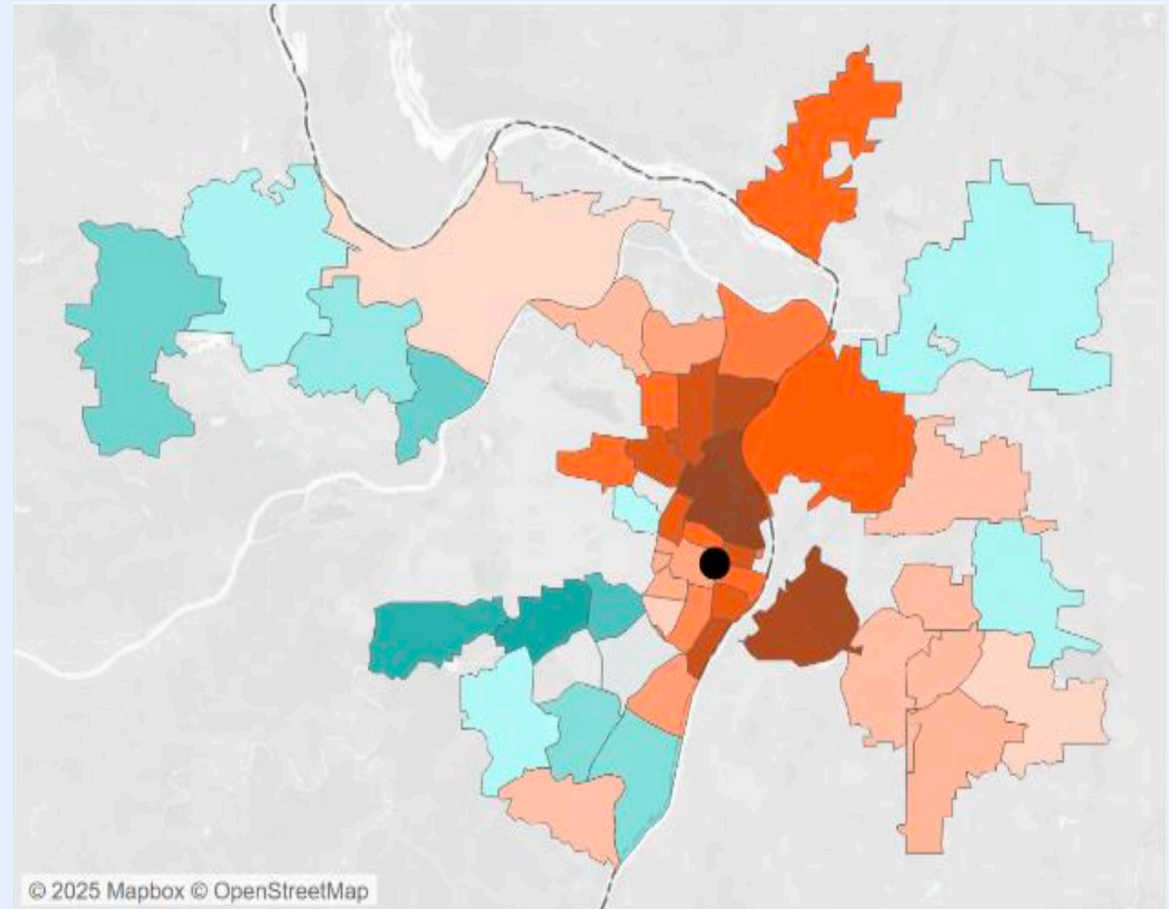
of distinct patients covered by Medicaid

3.3%

of distinct patients are Homeless (Diagnosis Code)

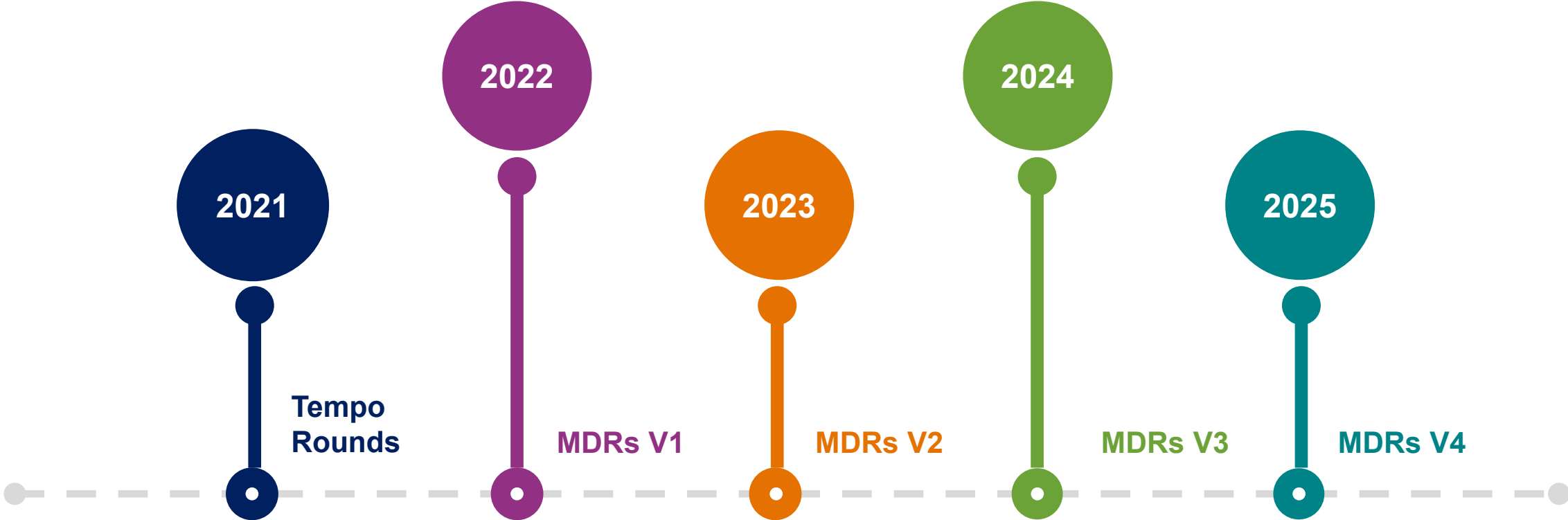
41.3%

of distinct patients with Behavioral Health Diagnoses

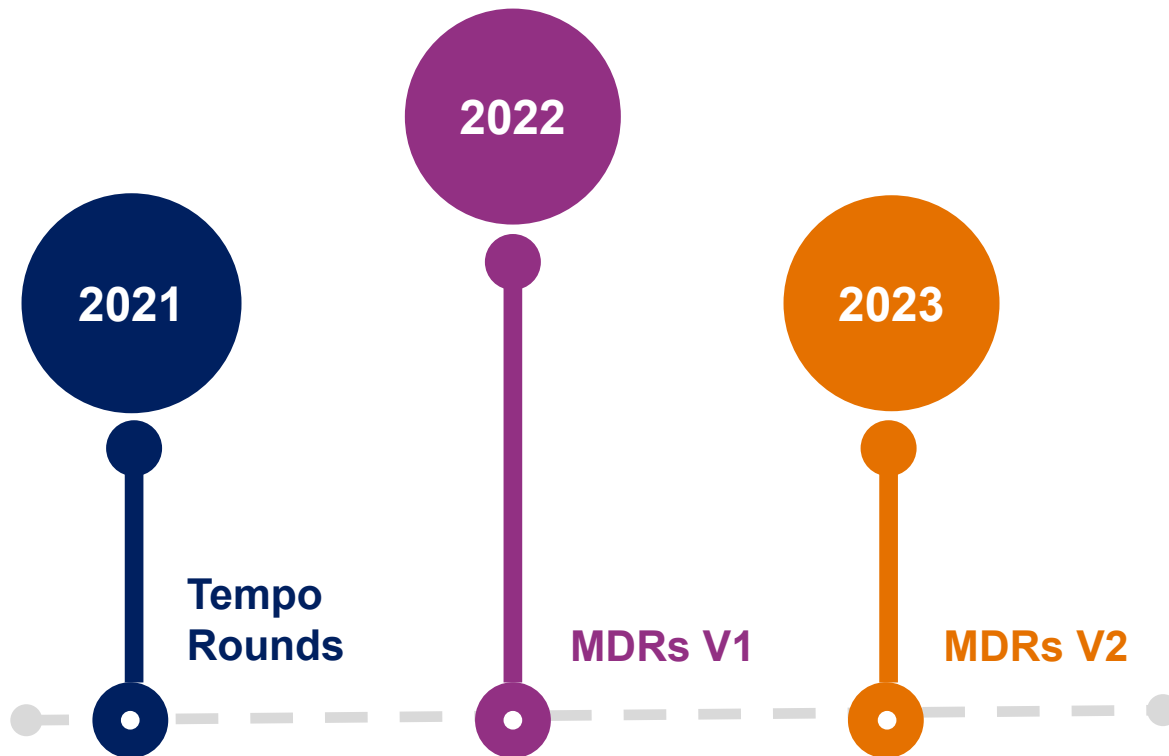


Data Source: Vizient Vulnerability Index Presentation

SLUH's Multi-Disciplinary Rounds Journey



SLUH's Multi-Disciplinary Rounds Journey



Tempo Rounds / MDRs V1 & V2

- **Timing:** Moved from 2:00PM to 10:00AM
- **Provider Involvement:** Moved from Phone-In to an In-Person Rotation
- **Facilitator:** Unit Nursing Leadership
- **Mandatory Attendees:** Care Coordination, Therapy, Pharmacy, Providers
- **Agenda:** Discharge Planning on every patient, everyday

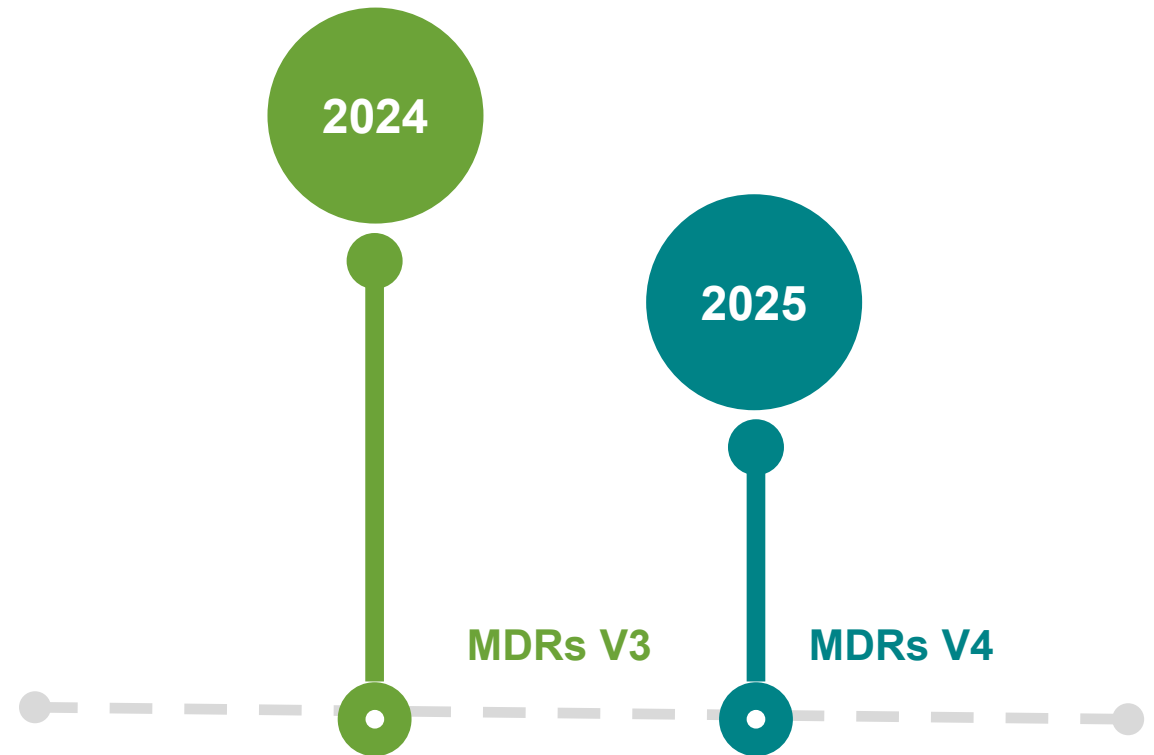
SLUH's Multi-Disciplinary Rounds Journey



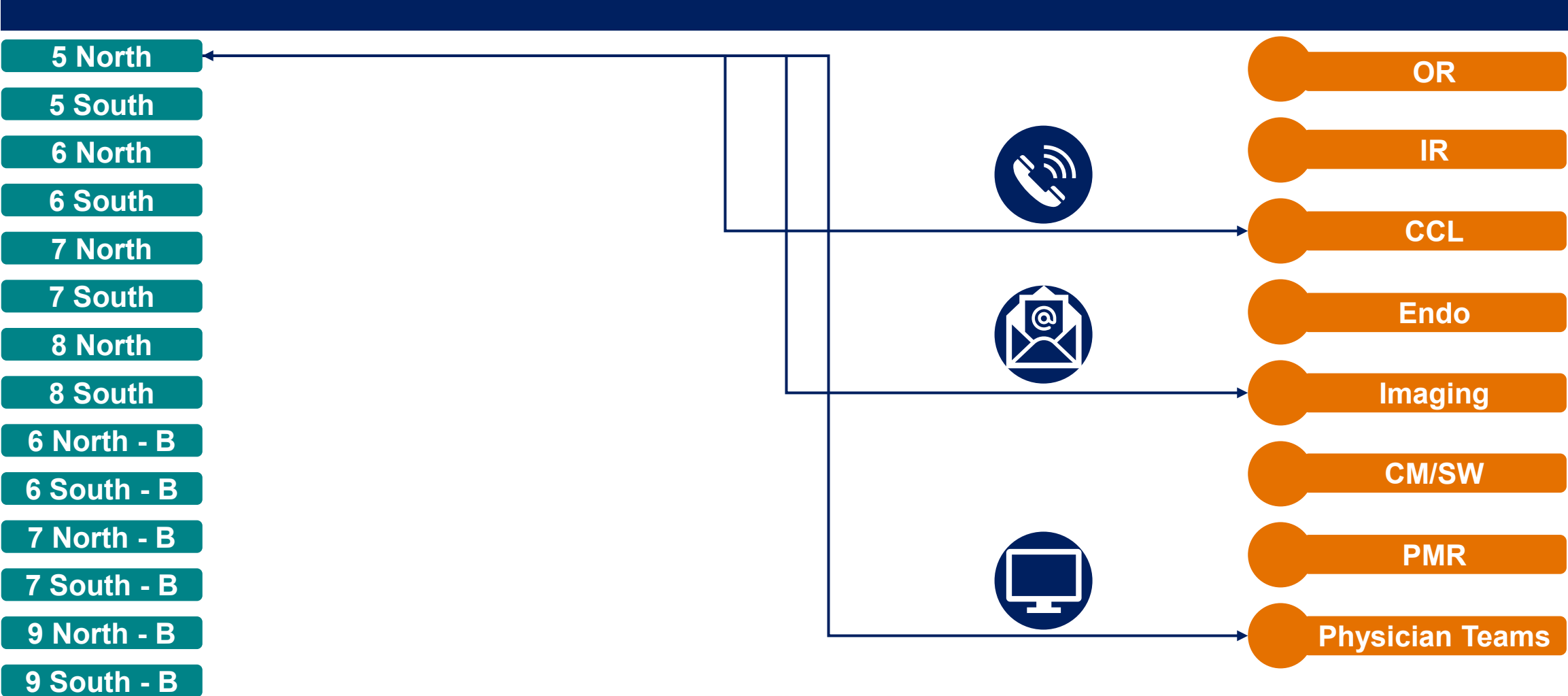
MDRs V3 & V4

Phases of Refinement and Innovation

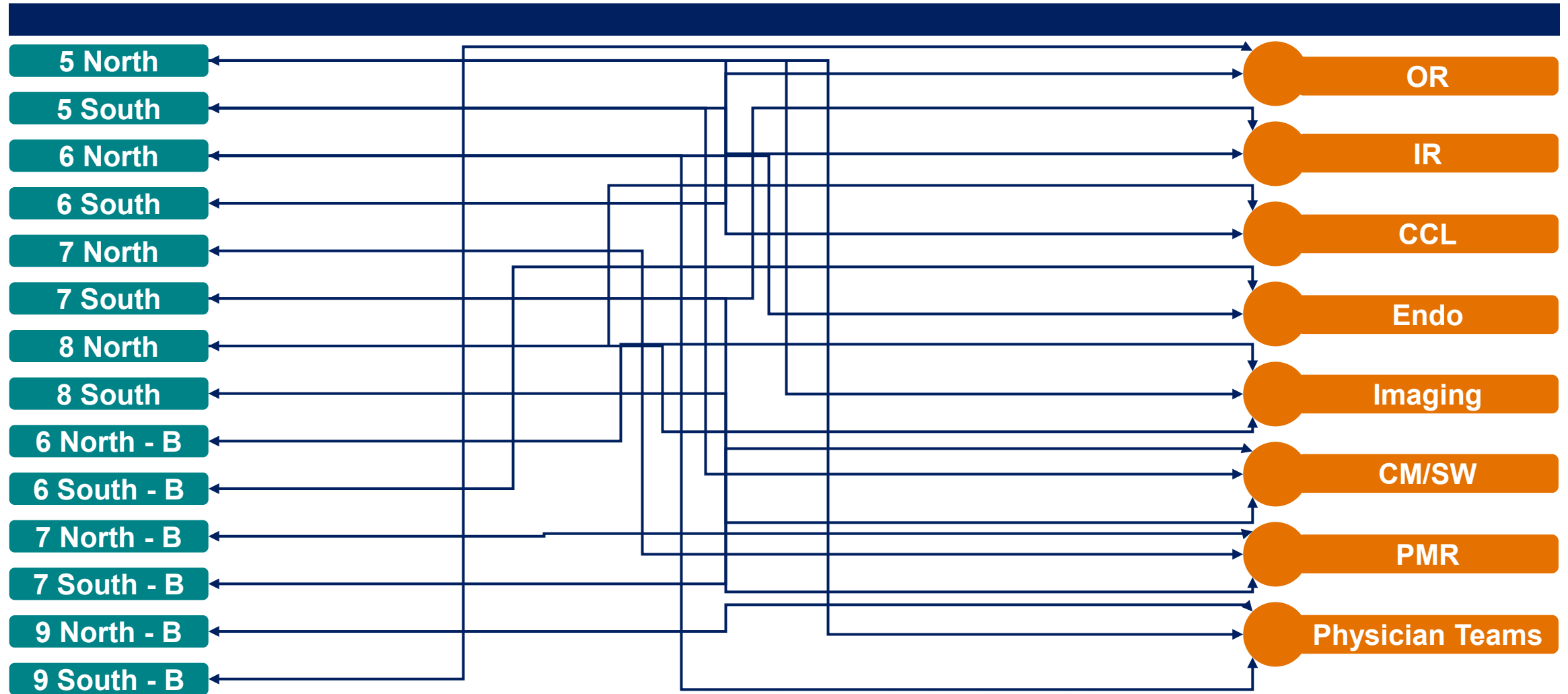
- Increased Campus Executive Team Collaborative Rounding
- Implemented a MDR Wrap-Up upon the Completion of Every MDR
- Further developed a 2:00 PM Touchpoint
- Implemented a Discharge Barrier Escalation Process



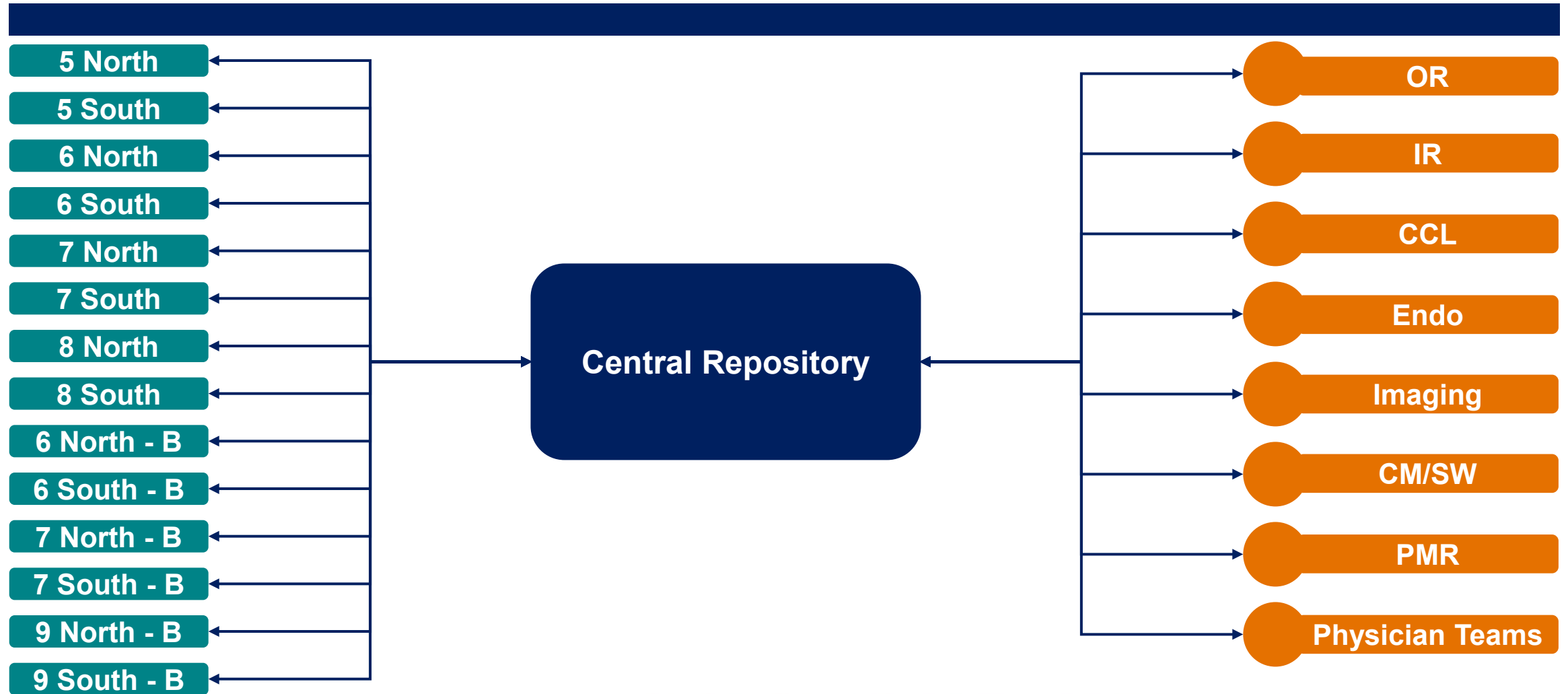
Prior State of Discharge Barrier Escalations



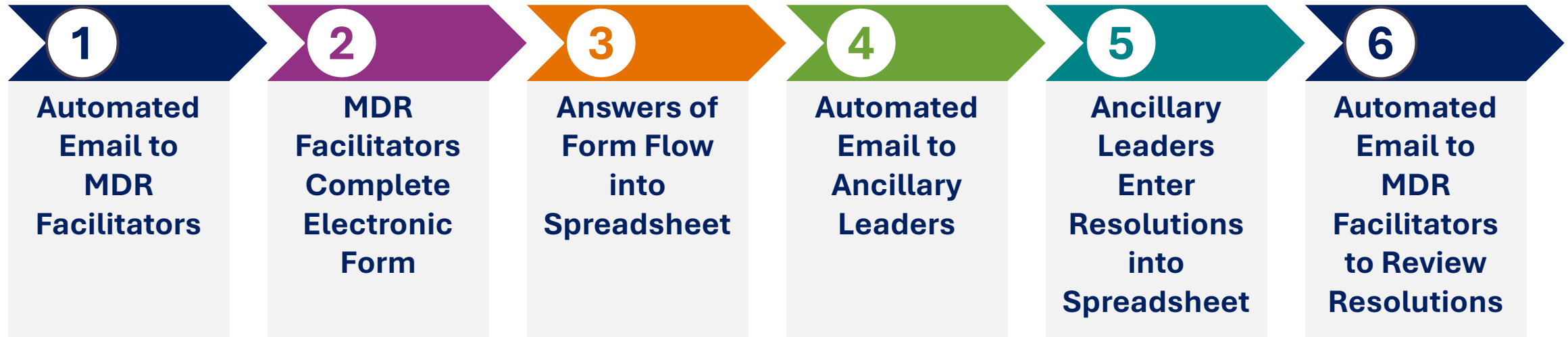
Prior State of Discharge Barrier Escalations



Future State of Discharge Barrier Escalations



V1 Discharge Barrier Escalation Process



V1 Escalation Process Results



October 2023 – January 2025

Escalations Entered

1,716

Resolutions Entered

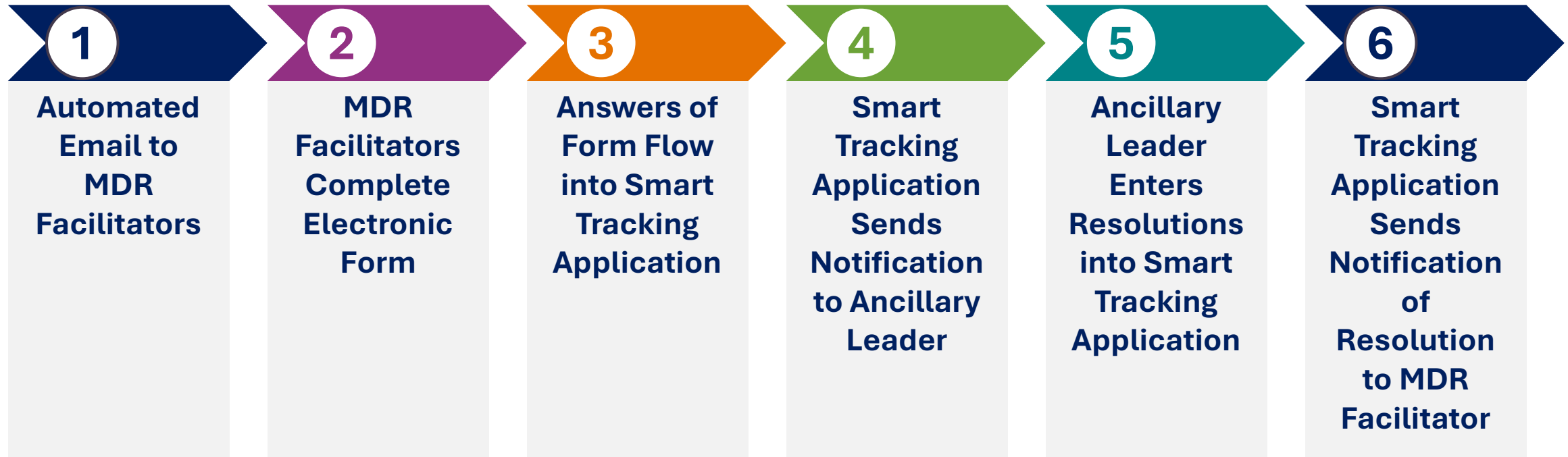
906

Response Rate

52.8%

Data Source: Internal SSM Health SLUH Spreadsheet

V2 Discharge Barrier Escalation Process



V2 Escalation Process Results



February 2025 – June 2025

Escalations Entered

299

Resolutions Entered

198

Response Rate

66.4%

Data Source: Internal SSM Health SLUH Smart Tracking Application

Sustainment and Governance



Lean Principles

Eliminate Waste
Empower Frontline Staff
Standardize Workflows
Continuous Improvement

HRO Principles

Deference to Expertise
Commitment to Resilience
Reluctance to Simplify
Sensitivity to Operations

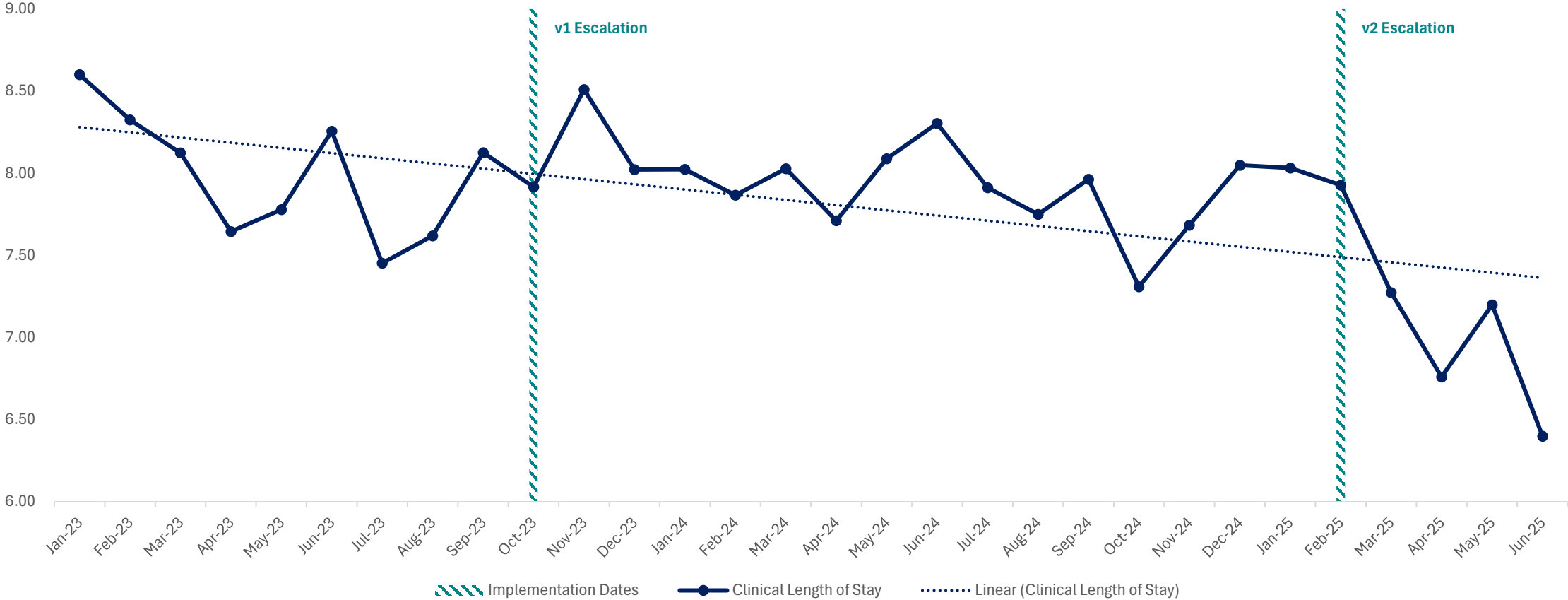
Governance

Monthly Patient Progression Meeting for
Open Feedback Regarding the Discharge
Barrier Escalation Tool

Clinical Length of Stay



SLUH Clinical Length of Stay

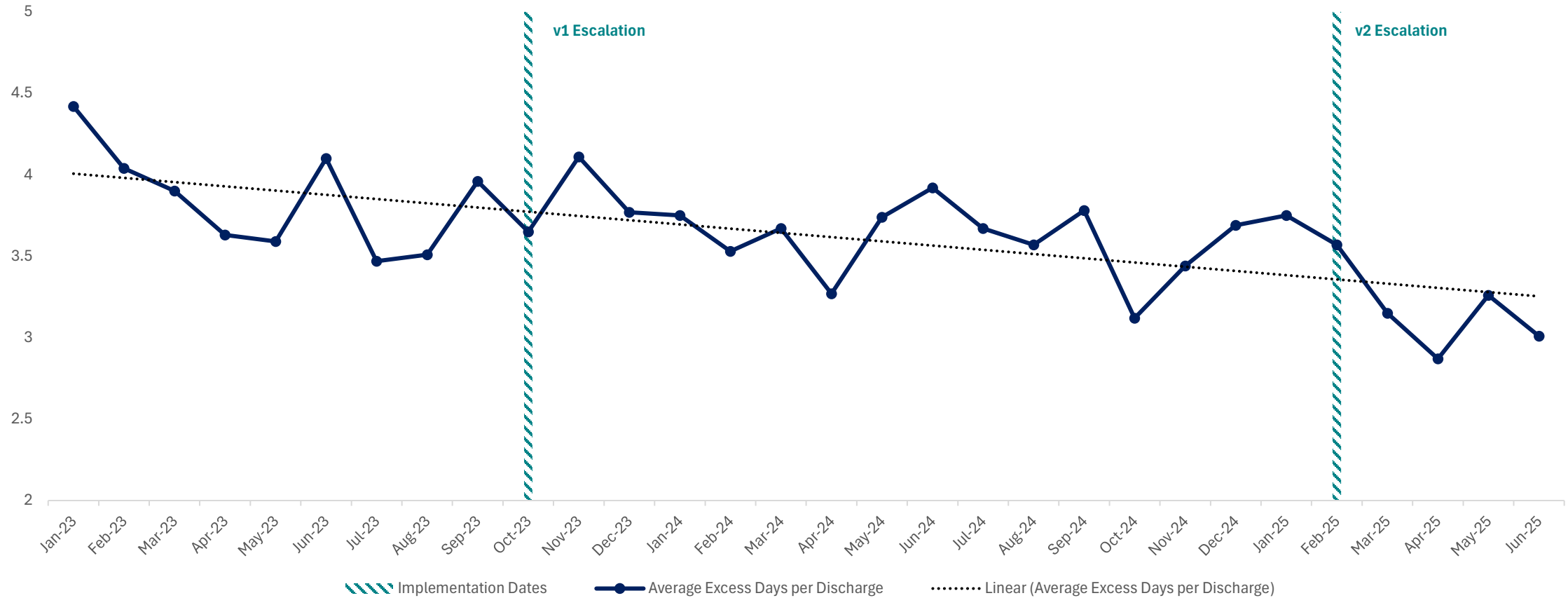


Data Source: Internal SSM Health Dashboard

Average Excess Days per Discharge



SLUH Average Excess Days above GMLOS per Discharge

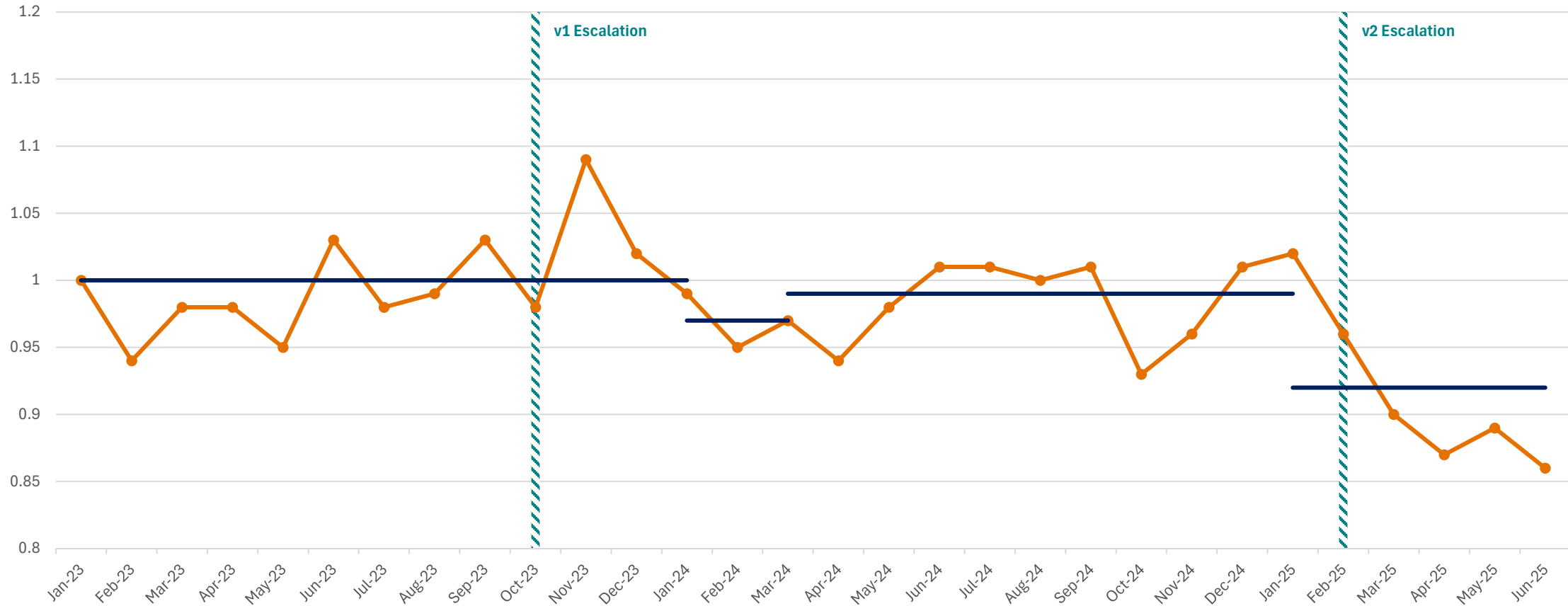


Data Source: Internal SSM Health Dashboard

Vizient LOS O:E Index



SLUH Vizient LOS O:E Index

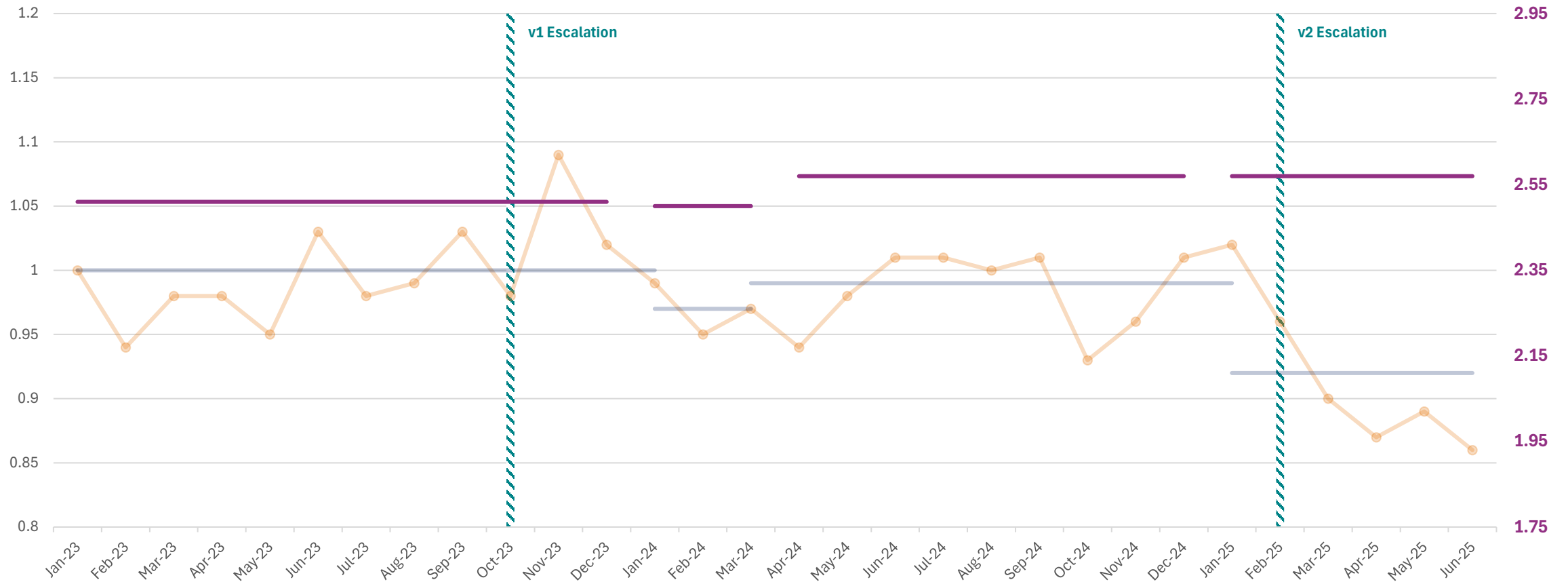


Data Source: Vizient Clinical Database

Vizient LOS O:E Index



SLUH Vizient LOS O:E Index



Data Source: Vizient Clinical Database

Results Summary



January 2023 – June 2025

Clinical Length of Stay

8.60 → 6.40
(↓25.6%)

Excess Days above GMLOS

4.42 → 3.01
(↓31.9%)

Vizient LOS O:E Index

1.00 → 0.86
(↓ 14.0%)

Data Source: Internal SSM Health SLUH Smart Tracking Application

Lessons Learned



- Establish the “What’s in it for me?” early and often.
- Defer to the expertise of your frontline staff.
- Notification fatigue is real and should not be ignored.
- Do not be afraid to make a change.

Key Takeaways



- Ensure all key stakeholders are included from the first meeting forward.
- Do not assume all leaders have the same technological skills, offer education of each step of the process.
- Establish a governance structure to field feedback on the process from all key stakeholders.

Questions?



Contact:

Thomas Conte, thomas.conte@ssmhealth.com

Adam Fritz, adam.fritz@ssmhealth.com

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Standardizing Multidisciplinary Rounds to Optimize Length of Stay

Libby Thomas, MBA, MIS, Director Internal Consulting

Krystal M. Garza, MSN, RN, CEN, NEA-BC, Senior Internal Consultant
Houston Methodist

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Learning Objectives



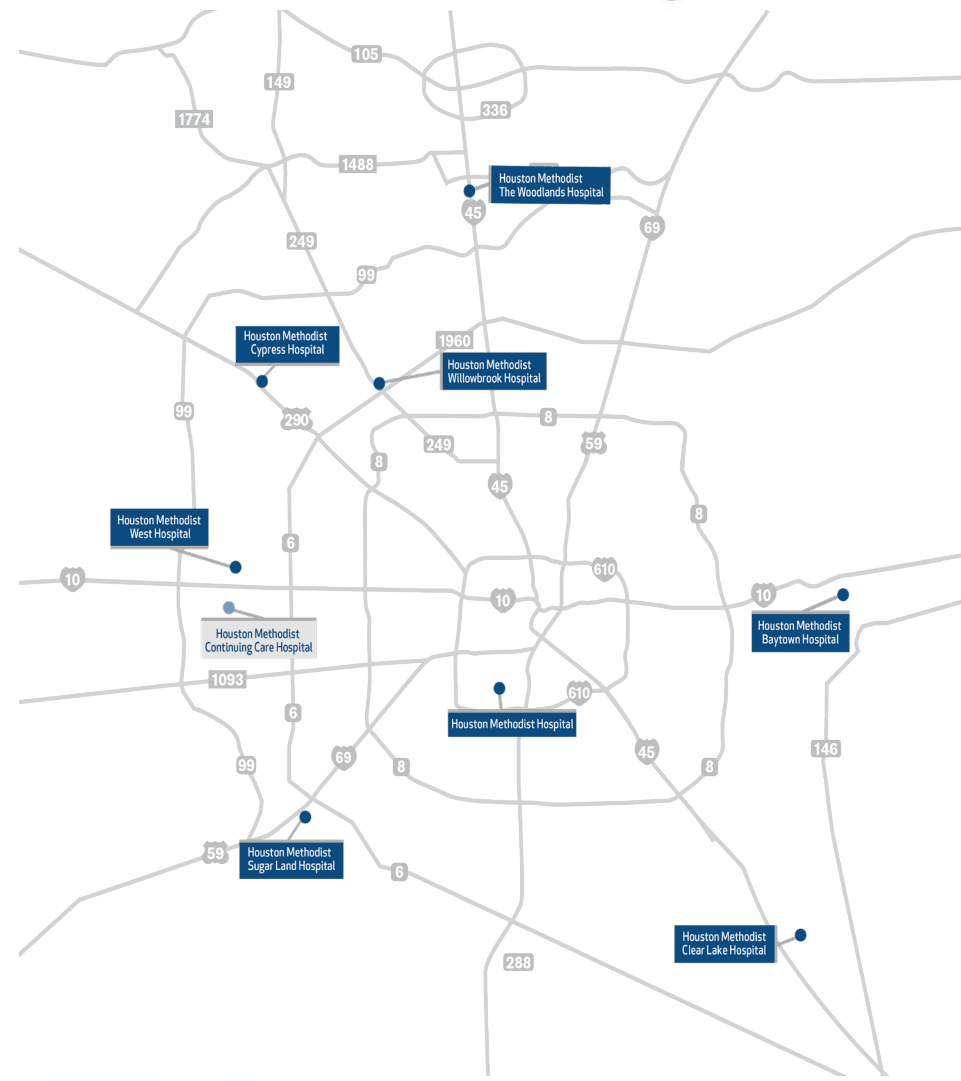
- How to utilize observation management tools to proactively identify patients.
- Identify the key roles within the care coordination team and their core responsibilities.
- Describe the purpose and components of an effective multidisciplinary round (MDR) template.
- Define key performance indicators (KPIs) relevant to care coordination and discharge planning.
- Understand the significance and role of a governance structure to promote patient progression within the acute care setting.

Houston Methodist – Journey to Unparalleled

Hospital With a Soul



1919	The Methodist Hospital first opened its doors as a 30 bed clinic during the Spanish flu epidemic
1996	The Methodist Hospital becomes The Methodist Health Care System (The Methodist Hospital, Diagnostic Hospital, San Jacinto Methodist Hospital)
8	8 acute care hospitals + 1 LTAC + Academic Institute
2,700	Acute care beds, 150k admissions/year
33,663	Employees
5,115	Affiliated Physicians



Houston Methodist Internal Consulting



LIBBY THOMAS
DIRECTOR



KRYSTAL GARZA
SENIOR INTERNAL
CONSULTANT



ABISHEK JOHNSON
INTERNAL
CONSULTANT



AMY MCBROOM
SENIOR INTERNAL
CONSULTANT



KENNY MOUTON
INTERNAL
CONSULTANT



BRITTANY PAGE
INTERNAL
CONSULTANT

- Began in 2018
- Focus: Operational efficiencies that can generate a return on investment (ROI)
- Guiding Principle – “If you do the right things the right way, the money will follow.”
- Our strength lies in the diverse, multidisciplinary backgrounds of our team members, who bring a variety of expertise such as:

Acute Care
Operations

Nursing

Utilization
Review

Finance

Epic

Value
Analysis

Human
Capital

Ambulatory
Care

Project Requirements

1. Executive Sponsorship
2. System Need
3. 5-10x Return on Investment (ROI)

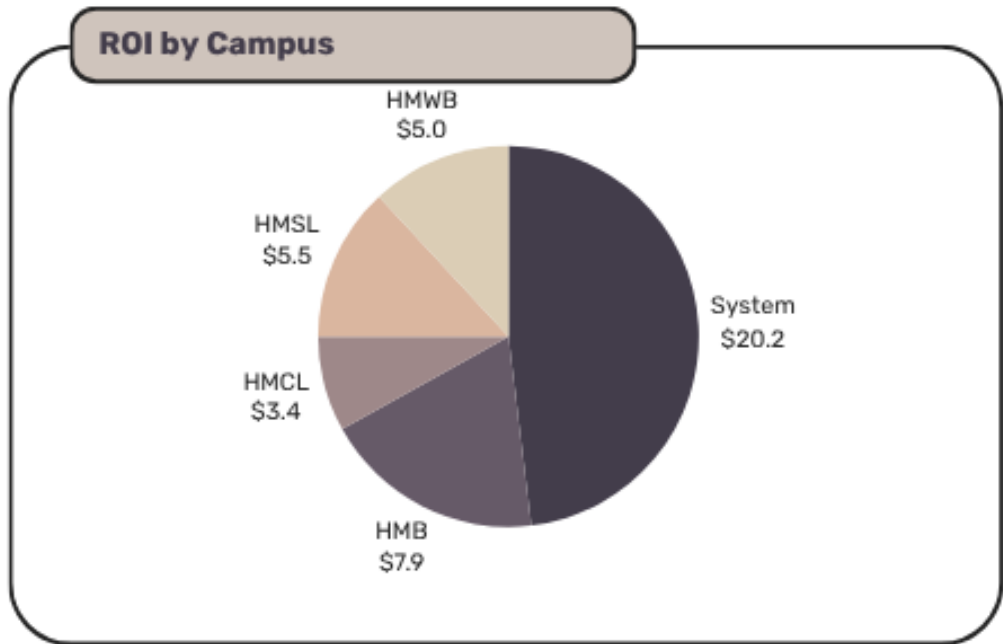
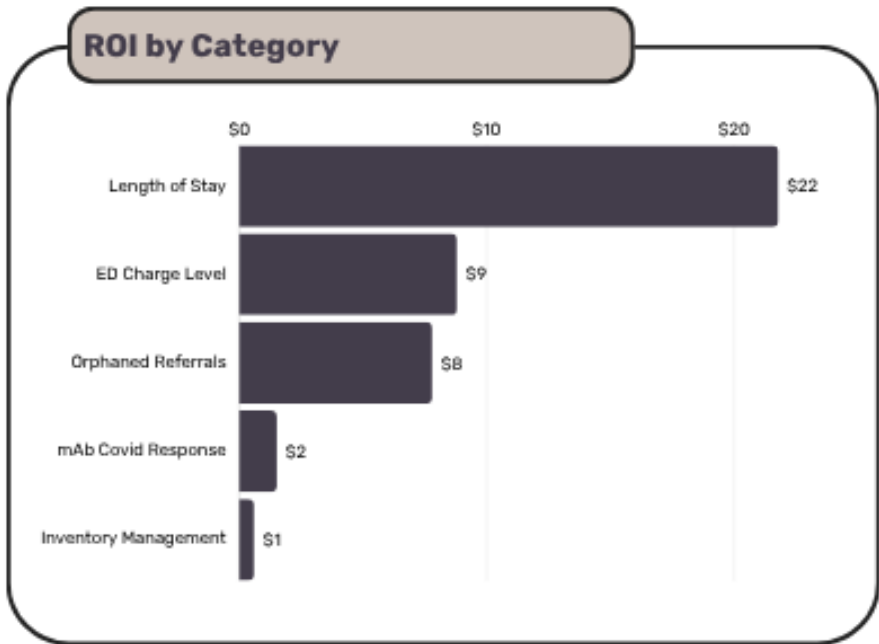
Lifespan Impact of the Team (2018-2025)



Lifespan ROI
\$42.0M

Cost Avoidance Contract Labor Savings Additional Revenue

\$1.6M **\$1.5M** **\$38.9M**






Data Source: HM Internal Consulting Database




Our Length of Stay Journey



HM IC + Hospital Partnered Implementation

HMCL	HMW	HMSL	HMWB	HMB
				
2020-2021	2021	2021-2022	2022-2023	2024-2025

Hospitals Implemented HMIC System Tools

HMH	HMTW	HMCY
		

Total HM IC LOS Impact \$21.8M

HMCL			
	Baseline	Jan-July 2025	12-month financial impact
LOS (days)	4.89	4.07	\$3.4M
Obs LOS (hrs.)	36.2	28.7	

HMSL			
	Baseline	Jan-July 2025	12-month financial impact
LOS (days)	4.81	4.56	\$5.5M
Obs LOS (hrs.)	33.4	28.3	

HMWB			
	Baseline	Jan-July 2025	12-month financial impact
LOS (days)	5.01	4.50	\$5M
Obs LOS (hrs.)	32.4	28.7	

HMB			
	Baseline	Jan-July 2025	12-month financial impact
LOS (days)	5.09	4.50	\$7.9M
Obs LOS (hrs.)	39.1	29.1	

Data Source: HM Internal Consulting Database

Components of LOS Improvement

imagine
THE POSSIBILITIES

1



Observation Patient Management

Proactive early discussions on patient status & relay plan of care

Case Management & Social Work partner to provide needed resources to facilitate discharge

2



Focused Care Coordination

Standardize roles & responsibilities for multi-disciplinary rounds (MDRs)

Incorporate real time coaching and escalation pathways

Educated 145+ front line & providers

3



Governance

Provide a dedicated venue to discuss performance

Highlight wins & problem solve as a team where there are opportunities for improvement

Proactive Observation Management Tools



Implementing an Observation Huddle

DISCUSSION GOALS:

- 1. Determine barriers to discharge
- 2. **Is observation status still appropriate, or should patient be converted to inpatient?**
- 3. What is keeping the patient from being discharged?



COMPONENTS OF A SUCCESSFUL MDR

1

ENGAGED & PROACTIVE TEAM MEMBERS

2

RIGHT PEOPLE PRESENT

Provider, Primary RN, Charge Nurse, Nurse Leader, Case Manager/Social Worker, Pharmacist, and Physical Therapist

3

IDENTIFY A LEADER

Establish roles & responsibilities for the leader and other participants

4

RIGHT DISCUSSION

Discharge focused discussion
Avg. 1 min/pt. If including bedside rounding, avg. 3 mins/pt.

5

START EARLY

Discharge touchpoints multiple times a day (afternoon, shift change, etc.)
MDRs complete by noon

imagine
THE POSSIBILITIES

MDR Roles and Responsibilities



Primary RN	Charge RN	Case Manager	Nurse Manager	Provider
Provides concise, discharge-focused patient feedback	Facilitator of MDRs **Set the tone/pace**	Secondary Lead of MDR **Set the tone**	Coaches/mentors staff & supports facilitators	MDR Lead
<ul style="list-style-type: none"> • Presents patient's clinical status & updates • Update the whiteboard • <i>No need to discuss pts being discharged</i> • Question inconsistent plans of care (and seek clarification) • Modifies Discharge Milestones/comments as needed in EHR (due to change in clinical status) • Discharged-focused patient summary 	<ul style="list-style-type: none"> • Ensures "flow" and has WOW available • Assists in seeking out clarification if needed • Covers for Primary Nurse if absent • Reconciles RTCM Dashboard for appropriate EDD and needed discharge orders • Day Charge: identifies 3+ <u>2pm</u> discharges • Night Charge: identifies 3+ <u>noon</u> discharges 	<ul style="list-style-type: none"> • Presents pt status: Inpatient (in days) Observation (in hours) • Discusses GMLOS • Helps provide feedback to Providers if needed • Modifies Discharge Milestones & comments as needed in EHR • <i>Modifies original EDD (provided by MD) as needed as backup only</i> 	<ul style="list-style-type: none"> • Assists in escalations if needed • Reconciles the RTCM Dashboard (f/u with charge RN) • Assigns follow-up tasks • Closes the loop for noon & 2pm goals (approx. 3pm) 	<ul style="list-style-type: none"> • Leads discharge-focused MDR • Provides clear plan of care • Updates family if needed • Determines and updates EDD in EHR

Standardized Multidisciplinary Round Template



MULTIDISCIPLINARY ROUNDS

Provider Led

Provider:
Room#: _____ Patient Name: _____ Reason for Admission/Dx: _____

CM/SW:
Status: Inpatient or Observation Length of Stay _____ Days (hrs if OBS) **GMLOS of** _____

Nurse:
Can patient discharge today? **Yes:** What time? _____ proceed to next patient
(Nurse responds to question) Transportation method? _____
No: Continue to next question

Can patient discharge tomorrow?
(Nurse responds to question) **Yes:** Can the patient discharge **before noon?** _____
No: Review **barriers for discharge** (skip to lower portion)

Is patient at baseline mobility? **Yes:** Proceed to next section
(Nurse responds to question) If not, has therapy been ordered? _____

Barriers for Discharge (Nurse to discuss)	Barriers for Discharge (CM/SW to discuss)
<input type="checkbox"/> Clinical status	<input type="checkbox"/> Placement needed: _____
<input type="checkbox"/> Pharmacy needs	<input type="checkbox"/> Authorizations needed/pending <input type="checkbox"/> Family aware
<input type="checkbox"/> Respiratory issues	<input type="checkbox"/> Home health orders?
<input type="checkbox"/> Telesitter	<input type="checkbox"/> DME <input type="checkbox"/> O2 <input type="checkbox"/> Family concerns
<input type="checkbox"/> Restraints	
<input type="checkbox"/> Pending consults	
<input type="checkbox"/> Central line _____ Discontinued	
<input type="checkbox"/> Foley _____ Discontinued	
<input type="checkbox"/> Wounds _____ Need consult?	

POST MDR Wrap Up (less than 5 minutes): RN Manager, Charge RN, CM/SW

- _ Review today's discharges
- _ Review tomorrow's DCBN
- _ Delegate action items/escalations

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LEADING MEDICINE

HMIC072025

- **Action oriented and collaborative setting**
- **Pointed Discussion (prompts on template)**
 - Must discuss patient class status (OBS or INPT)
 - Imperative to discuss GMLOS and current LOS
- **Communication expectations for each discipline identified**
- **Proactive patient management (wrap up discussion)**
 - Anticipated Post-Acute Placement
 - Anticipated Transportation after Discharge

Post MDR Wrap Up



01

Review today's discharges



02

Identify tomorrow's discharges



03

**Communicate and clarify any escalations
or concerns**



04

**Unit-based afternoon follow-up with
leadership**

GOVERNANCE



LEADER ROUNDING



- Nurse & CM Managers attend MDRs 3 times per week
- Nurse and CM Directors attend MDRs 2 times per week
- Executives attend MDRs once per week

RESPONSIBILITIES

- Escalation support and barrier resolution
- Observation and insight
- Coaching and professional development
- Identify trends and process gaps
- Reinforce accountability and priorities

PATIENT PROGRESSION



- Establish a monthly governance meeting with relevant hospital leaders and providers
- Action-focused meeting (not report out)
- Use KPIs and audit scores to determine processes that should be addressed

RESPONSIBILITIES

- Focused review of complex patient trends
- Use data to drive decisions
- Support throughput and discharge efficiency
- Help remove barriers from the frontline

MDR AUDITS



- 1 audit/unit/day
- Establish a multidisciplinary group to perform audits and to provide feedback to the patient progression meeting
- Utilize an abbreviated tool to aid leaders in objectively assessing MDR effectiveness

RESPONSIBILITIES

- Real-time coaching
- Ensure standardization and consistency
- Identify gaps in communication
- Collect data for improvement
- Build rapport with staff

Patient Progression KPIs



ED	Observation	Inpatient	MDR	Readmissions
<p>ED LOS</p> <ul style="list-style-type: none"> • D/C LOS • Admit LOS <p>Bedded Percentages</p> <ul style="list-style-type: none"> • % Admit • % Observation <p>ED Boarder Rate</p> <ul style="list-style-type: none"> • Med/Surg Boarder Rate • Critical Care Boarder Rate <ul style="list-style-type: none"> • % LWBS • % Eloped • % AMA 	<p>Obs LOS</p> <ul style="list-style-type: none"> • Obs Status Only • Total Encounter <ul style="list-style-type: none"> • % Cases > 2 Midnights (Medicare) • % Cases > 48 Hours 	<ul style="list-style-type: none"> • IP LOS • IP LOS • Observed/Expected Ratio • # of Avoidable Days <p>Discharge Timeliness</p> <ul style="list-style-type: none"> • Anticipated D/C Accuracy • % D/C Orders by 11am • % D/C by 12pm • % D/C by 2pm <p>Room Turnaround</p> <ul style="list-style-type: none"> • D/C to Next Patient • Bed Clean to Next Patient • Bed Dirty to Bed Clean 	<ul style="list-style-type: none"> • Leader Audit Results • Process Successes • Process Challenges • Variation, Barriers & Opportunities 	<ul style="list-style-type: none"> • Total Readmission Rate • Top Readmission Diagnoses/Reasons

Lessons Learned

Lessons Learned



Know your audience

- Translate the **why** based on specialty
- Use the ADKAR model for change management



1 Active executive sponsorship is foundational to early adoption



Reeducate on how to best leverage your EMR

Better leveraging the EMR has proven essential for improving data accuracy, communication, and overall efficiency



All things are good in MODERATION

Continue the focus on improving efficiency, sometimes moving a specific KPI can be a distraction



Involve Both Providers & Patients

- Physician led rounds has accelerated decision making and improved outcomes
- Incorporating in-room rounding has improved care alignment and patient satisfaction



Be flexible

Tools and processes have evolved over our 5-year journey



Key Takeaways



KEY TAKEAWAYS

Proactive discharge planning
(plan A, plan B, plan C
& work it!) 01

Key to sustainment is
establish continuous
feedback loops & governance 02

Emphasize consistency 03

Leverage your Physician
Advisor 04



Questions?



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Closing and Next Steps

Thank you for being part of today's Peer to Peer Education Meeting! We hope you leave with new ideas, real-world strategies, and connections that support your work ahead.

Put today into practice

- Take one idea back to your team to explore this month
- Connect with a peer you met today to keep the conversation going throughout the conference

What's ahead at the Summit

- Education Posters and Sessions
- Networking Reception tonight at 5:30 p.m.
- General Session tomorrow