The Long Road Home: Improving Hospital Throughput by Identifying Delays to Discharge at Valley Medical Center

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PURPOSE

The purpose of this study is to map the current VMC discharge process and identify underlying barriers that delay discharges unnecessarily. Findings will inform our recommendations to facilitate discharges before noon and decrease the time between the initiation of a discharge order and when the actual patient discharge occurs.

METHODS

This ten-week mixed methods case study was conducted on 2-West, a 34-bed unit at VMC that provides behavioral health, oncology, and general care services. During this time, we conducted a focused scholarly literature review and completed an analysis of internal policy documents. In addition, we conducted a data collection analysis by:

- Attending morning discharge rounds on Thursdays and Fridays
- Shadowing and interviewing key stakeholders of the discharge process
- Distributing surveys to clinical, administrative, and allied health professionals
- Organizing and analyzing data from Epic regarding discharge activity
- Conducting direct observations to develop a process map

RESULTS

The process map depicts steps applicable to all patients when discharged to home; however, what occurs between each step may be unique to each individual patient. Some steps may not be considered value-added from the patient’s perspective.

Common barriers were identified from (1) attending morning discharge rounds, (2) obtaining survey results, and (3) conducting interviews with key stakeholders involved in the discharge process.

Stakeholder | Identified Barriers of the Discharge Process (Discharge Rounds & Surveys)
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Hospitalist | Waiting for ancillary service/consultations, waiting for IV team services, transportation, waiting for discharge order, discharge planning, social, financial support at home, communication, waiting for insurance verification, waiting for home health needs, communication, waiting for ancillary service/consultations
Nurse | Waiting for ancillary service/consultations, waiting for pharmacy, waiting for IV team services, transportation, waiting for discharge order, discharge planning, nurses not putting planning before orders are written, patient safety, amount of charting, paperwork, hospital nurse workload, waiting for insurance verification, waiting for home health needs, communication
Discharge Planner | Waiting for discharge, transportation, DME delivery, family not responding
Physical Therapist | Insurance coverage for resources (equipment, caregivers, etc.), communication
Respiratory Therapist | Communication, getting order for home oxygen
Social Worker | Lack of resources, lack of compliance
Pharmacist | Waiting for ancillary service/consultations, waiting for pharmacy, waiting for IV team services, transportation, waiting for discharge order, pharmacy availability and acceptance, communication
Nurse Leadership | Waiting for ancillary service/consultations, waiting for pharmacy, waiting for IV team services, transportation, waiting for discharge order, communication, accountability

When orders are written earlier, it takes longer for the care team to get patients discharged.

RECOMMENDATIONS

After finding best practices from literature, outlining the current state of VMC’s discharge process, and gathering key stakeholder perspectives, our recommendations support activities in the areas of: (1) communication, (2) prioritization, and (3) standardization. Recommendations are prioritized based on cost, effectiveness, and feasibility, as these categories are used by VMC to make decisions regarding resource allocation. The top five recommendations include:

1. Prioritizing communication among the care team
2. Implementing a standardized discharge process
3. Reviewing and updating discharge rounds
4. Enhancing ancillary service coordination
5. Streamlining discharge documentation

CONCLUSION

Foremost at VMC is putting patients first by providing high quality, safe, compassionate, and cost-effective healthcare. The discharge process is a signal to patients that a transition in such care is imminent and specifies the end of the inpatient experience. As such, the transition from inpatient care through discharge must be well managed. Common obstacles identified during our study support the assertion that impediments lie within the thematic areas of communication, prioritization, and standardization. Our recommendations address these challenges and promise to streamline the inpatient discharge-to-home process, the primary goal of this study. Future efforts to advance the discharge process by incorporating such patient-centered recommendations will allow VMC to realize even greater alignment with its stated mission and vision.