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

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BACKGROUND

When healthcare organizations face operations at full capacity, many bottlenecks occur. Consequences of suboptimal discharge processes during times of high capacity include ED overcrowding, PACU closures, and dissatisfied patients and families. Valley Medical Center (VMC), therefore, set about to examine the discharge process in an effort to optimize utilization of existing inpatient beds by moving patients efficiently and effectively through the hospital system. The underlying assumption is that if they could increase the total daily discharge rate occurring before noon, patient satisfaction would increase and capacity improvements will be realized. Within this context, we ask: *How can a public district hospital streamline the patient discharge-to-home process?*

To answer this question, we explore the following:

(1) How does communication among the multidisciplinary team affect the discharge process?
(2) How are patients prioritized to promote effective discharges?
(3) How can incorporating standardization influence the discharge process?

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.

Communication **Prioritization** **Standardization**

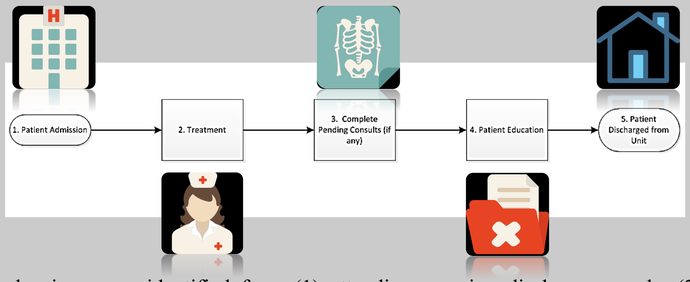
METHODS

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 current state 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

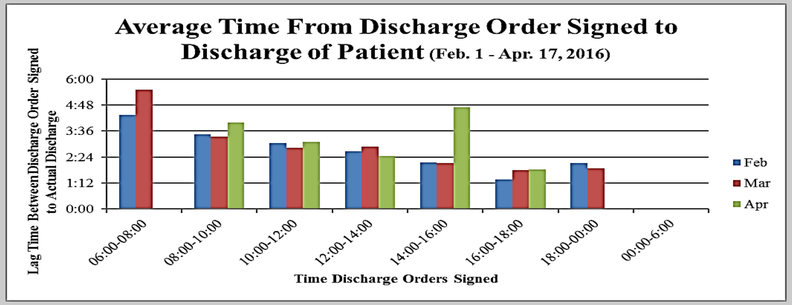
The process map depicts steps applicable to all patients when discharged to home; however, what occurs between each step may be unique to each individual patient. Some steps may not be considered value-added from the patient's perspective.



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)
Hospitalist	●Waiting for ancillary services/consultations ●Waiting for IV team services ●Transportation ●Waiting for discharge order ●Discharge planning ●Social, financial support at home ●Communication ●Getting paged by the ER (dealing with admissions)
Nurse	●Waiting for ancillary services/ consultations ●Waiting for pharmacy ●Waiting for IV team services ●Transportation ●Waiting for discharge order ●Discharge planning ●Nurses not planning before orders are written ●Patient Anxiety ●Amount of charting, paperwork ●Hospitalist/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 services/ consultations ●Waiting for pharmacy ●Waiting for IV team services ●Transportation ●Waiting for discharge order ●Family availability and acceptance ●Communication
Nurse Leadership	●Waiting for ancillary services/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.



Care Team Perspectives

Hospitalists

- Tend to spend most of morning in ICU
- Inconsistent charting, rounding
- Nurses hesitant of writing verbal orders
- Communication difficulties

Nurses

- No notification mechanism
- Heavy morning workload
- Patient requests
- Waiting on consults and pharmacy

Pharmacists

- Some Rx require prior authorization
- Rx filled in the order received
- Difficult getting patient off IV meds to PO
- Waiting on order for patient education

Physical Therapists

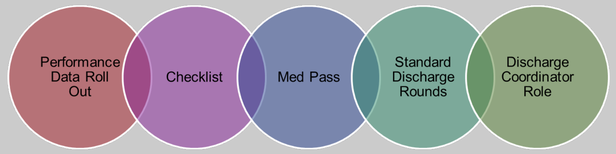
- Acquiring equipment for patients
- Need role clarity
- Discharge rounds not focused on discharges
- Consults not within scope

Discharge Planner

- Minimal involvement in home dispositions
- Transportation
- Limited support at home
- Process sometimes starts at admissions

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:



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 immanent 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.