

Expediting Discharges on the Inpatient Medicine Teaching Services

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Introduction: Delayed discharges can adversely affect patient flow throughout the hospital. Late afternoon discharges may lead to high hospital occupancy, admission bottlenecks, ER overcrowding, and disrupted ICU transfers. Discharge by noon (DBN) is key to enhancing hospital capacity, bed utilization, and patient satisfaction and outcomes. Last year, DBN for patients returning home with or without home care services (HHC) was chosen as one of three annual priorities for our hospital medicine division. This was implemented in October 2023 but did not gain momentum among the medical resident teaching services (MTS), paving the way for our QI project.

Model for Improvement: Baseline data on the percentage of MTS DBN to home and HHC were available from November 2023 to January 2024. We surveyed our residents/faculty and conducted a root-cause analysis. The main barriers to DBN included a lack of planning and motivation, delayed communication with case management, and prolonged rounding.

Aims Statement: Our goal was to increase the median percentage of MTS discharge orders placed by noon to home and HHC from 22% to 35% within 3 months.

Measures: Our primary outcome measure was the percentage of MTS DBN to home and HHC. Weekly EMR-generated reports were collected. The outcome measure was then calculated and uploaded weekly on a run chart for analysis. Qualitative process measures included assessing if residents were planning discharges and documenting the number of discharges completed before noon.

Changes: Our interventions targeted the lack of planning and motivation. These included introducing the expedited initiative and its importance to residents/faculty through conferences. In addition, a process was created where potential next-day discharges were discussed at afternoon sign-out and a tracking chart of DBN orders was designed for each team room.

Tests of Change: Our pre-intervention median percentage of MTS DMB to home and HHC was 22% and improved to 40% post-intervention. While we observed a variation in discharge practice based on the rounding attending, we had notably sustained an upward shift in practice from our baseline when data was plotted on a run chart. We are currently continuing data collection to track sustainability and variability among rounding physicians.

Conclusion: We attained an upward shift in the percentage of MTS DBN to home and HHC post-intervention. Although an upward shift has been achieved, we are looking to sustain and further improve it. In future PDSA cycles, we will look at individualizing feedback and optimizing interdisciplinary rounds. We plan on further investigating balancing measures such as bed availability, discharge timing for rehabilitation destinations, and patient and staff satisfaction.