Multidisciplinary Rounds - Impact on Discharge Timeliness

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UTILIZATION MANAGEMENT / PVAMC

BACKGROUND

- Increased demand for hospital beds – limited resource

- FY2018 - ED over 75% capacity from 1100-1900 and over 100% capacity from 1200-1700.
  - Early morning discharges help align inpatient capacity with clinical demand – avoiding gridlock that negatively impacts patient care.

- FY2018 - 29% of medical patients discharged before 1300 (25% on the general medicine services and 35% on the hospitalist services).
  - VISN goal - 40% of discharges completed before 1300

- Improvements in patient throughput will result in increased patient satisfaction and improved access to care.

PICO(T) QUESTION

Will the implementation of a second discharge centered afternoon huddle (**I**) on the general medicine teams (**P**) increase the percentage of patients discharged before 1300 (**T**) to 40% (**O**) compared to having one morning meeting (**C**)?

Evidence Summary

- Literature review completed:
  - Evidence from studies at 5 large academic teaching hospitals suggest that:
    - Physicians are able to correctly predict more than 2/3 of actual next day discharges.
    - Implementing a discharge checklist during the afternoon huddle and completing key discharge orders the night prior to discharge resulted in 10-25% increases in discharges by noon (i.e. 11% 37% of DCs by noon).

Medicine Discharge Population Study

Population Excludes:

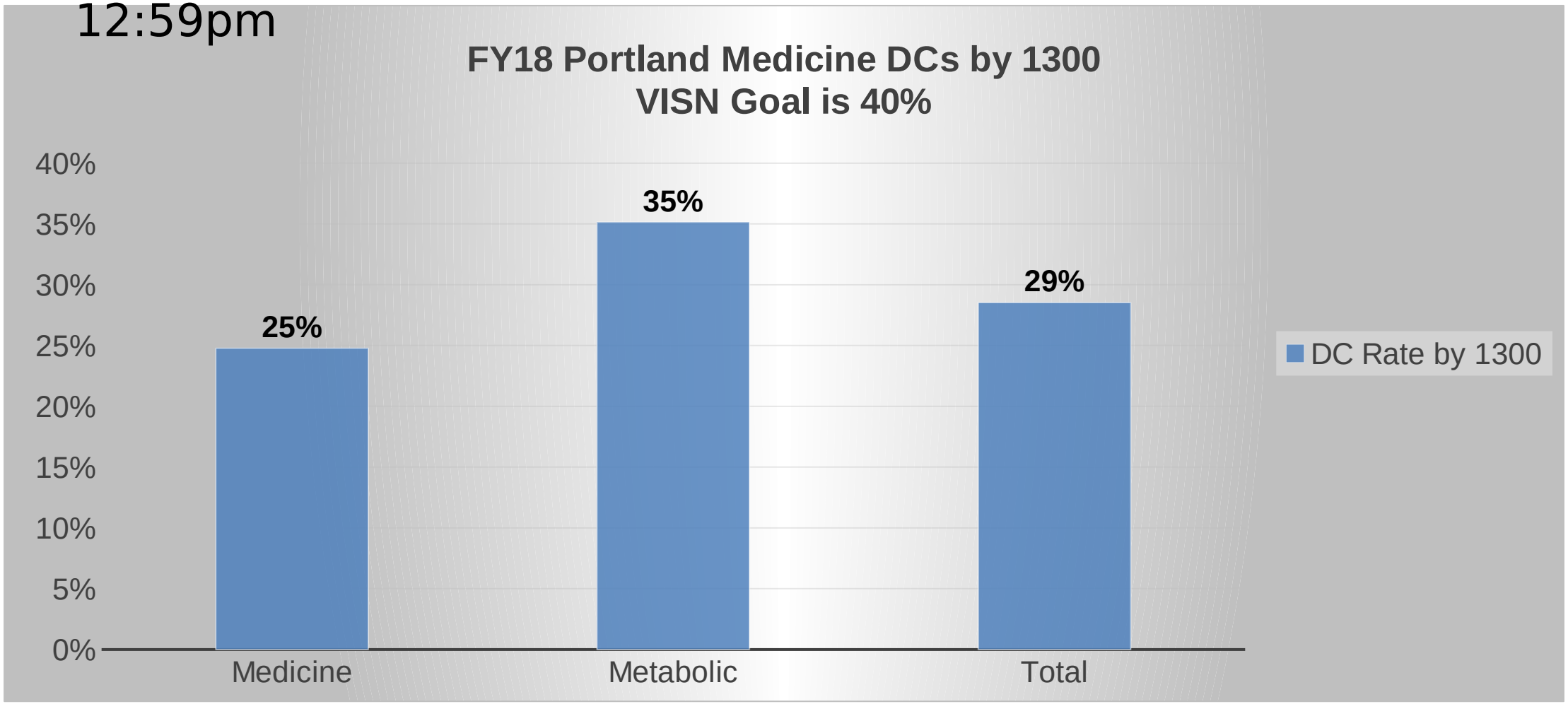
- Death as reason for DC
- Hospice, Observation, Cardiology and Medicine ICU treating specialties.

Population Includes:

- General Medicine and Metabolic (CHS) treating specialties
- If Medicine wrote the DC order regardless of what service (Surgery/Behavior Health) admitted.

FY2018

* DC by 1300 counts all DCs that calendar day after midnight until 12:59pm



2018 February-May DC Times

DC Hour	General Medicine	Metabolic	Total
7	3		3
8	3	1	4
9	7	11	18
10	18	17	35
11	46	54	100
12 TARGET DC TIME	79	44	123
13	111	66	177
14 PEAK DC HOUR	135	69	204
15	112	65	177
16	94	29	123
17	54	19	73
18	35	6	41
19	15	6	21
20	3	2	5
21	1		1
Grand Total	716	389	1105
DC by 1300	156	127	283
Rate by 1300	**22%**	**33%**	**26%**

ACTION PLAN

- Afternoon interdisciplinary meeting with attending (or resident when appropriate), social work, UM, and pharmacy.
  - Time varied day-to-day
  - Discharge centered
  - Utilized a discharge checklist
- Intervention implemented from 2/5/19-5/31/19 on GM1, GM2, GM3, and GM5 teams with patients across all acute care inpatient units
- Primary Outcome:
  - Calendar month discharge by 1300 (reported as a percentage)
- Secondary Outcomes Measured:
  - LOS
  - Readmission Rate

Discharge Checklist

Discharge Checklist:	Date Achieved:	Addtl Comments:	Responsible Team
Pt ID:	**N/A**		**N/A**
Patient aware of EDD:			**MD**
Family/Caregiver aware of EDD:			**MD**
Residential/NH aware of EDD:			**SW**
Specialty equipment ordered/delivered:			**MD**
Transportation arranged: (please specify how the patient will be discharging and at what time travel is arranged in comments).			**SW/MD**
Discharge paperwork completed and unsigned night before anticipated dc.			**MD**
Nursing alerted to possible dc:			**UM**
Barriers to signing dc			**N/A**

RESULTS – February 2019

Pilot start on GM3

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4 discharges within 30 minutes of 1300 (81% if dc’d in time)

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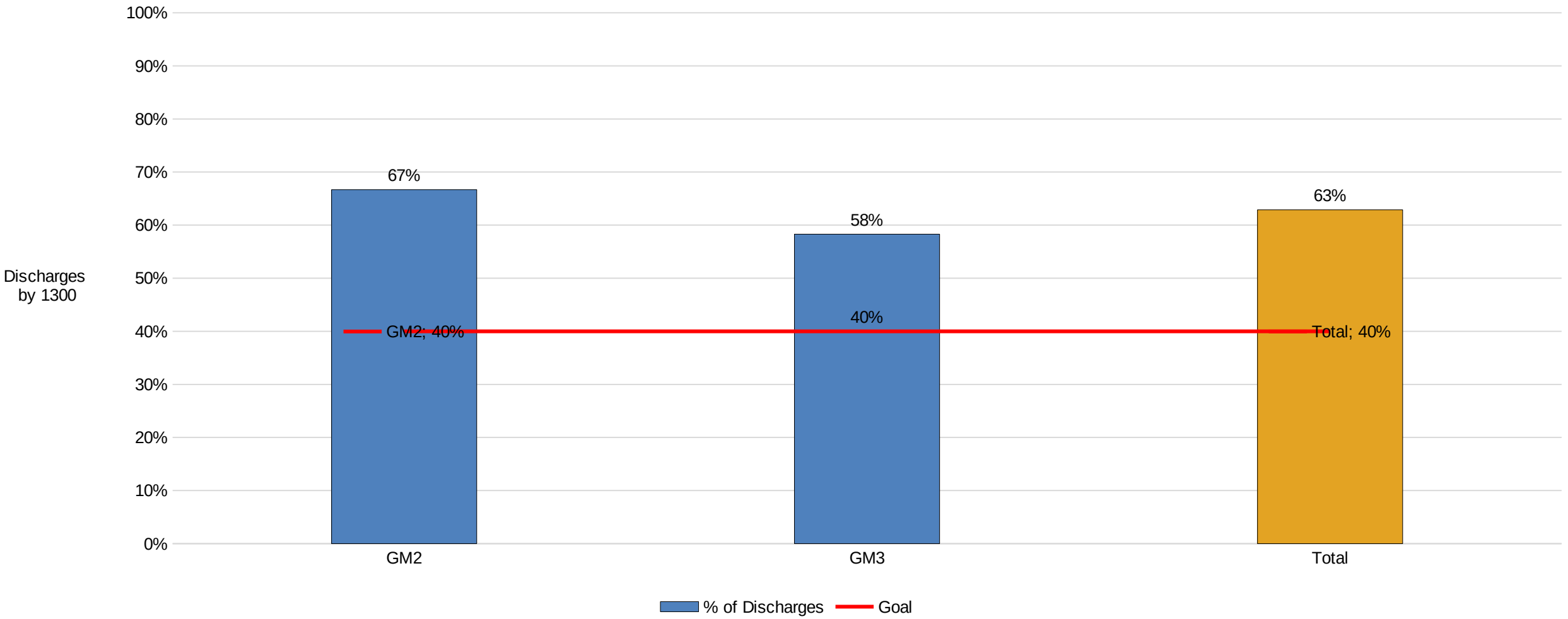
RESULTS - March 2019

- Pilot expanded to include GM2 on 3/5-

GM3 w/ 3 discharges within 30 minutes of 1300 (83% if dc'd in time), GM2 w/ 2 discharges within 30 minutes of 1300 (80%).

Discharges by 1300 - March 2019
GM2/GM3

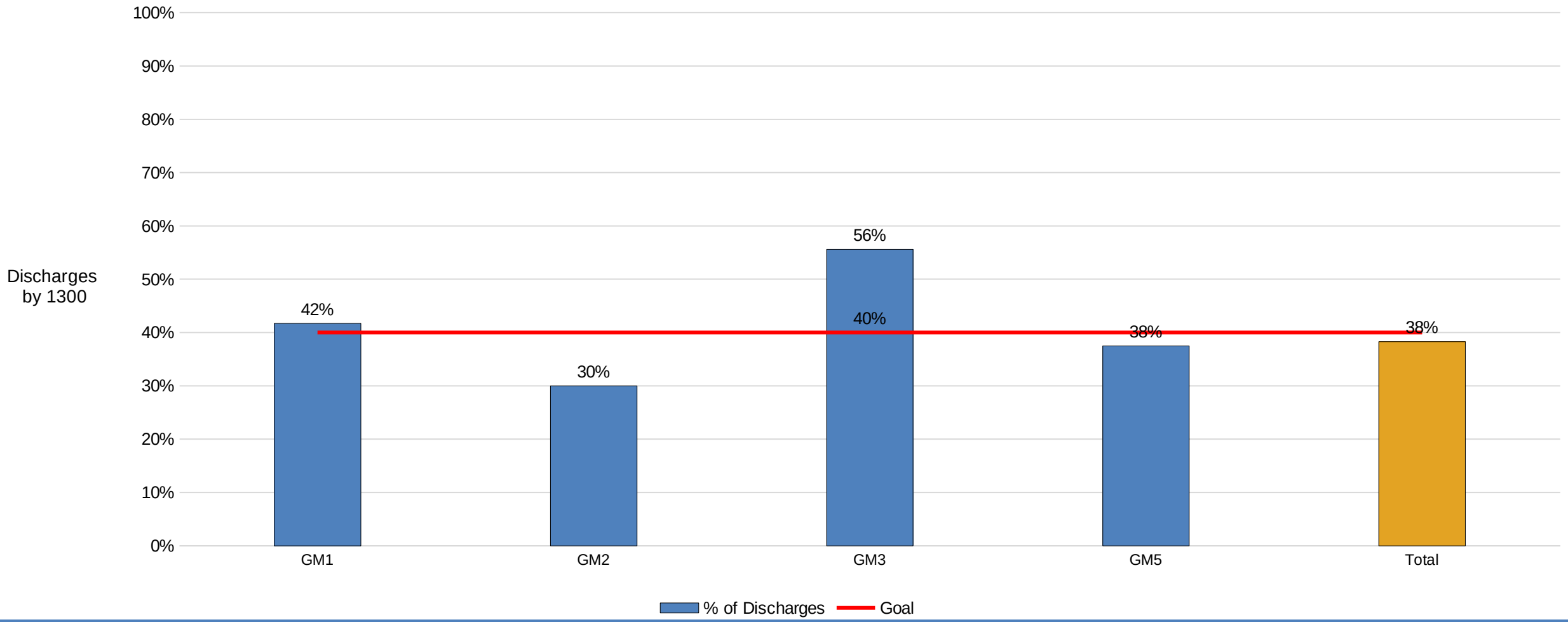


RESULTS - April 2019

-Pilot expanded to include GM5 on 4/9 and GM1 on 4/23-

GM3 w/ 3 discharges within 30 minutes of 1300 (72% if dc'd in time), GM5 w/ 5 discharges within 30 minutes of 1300 (68%). GM2 w/ 3 discharges within 30 minutes of 1300 (38%) , GM1 w/ 1 discharges within 30 minutes of 1300 (50%).

Discharges by 1300 - April 2019
GM1/GM2/GM3/GM5

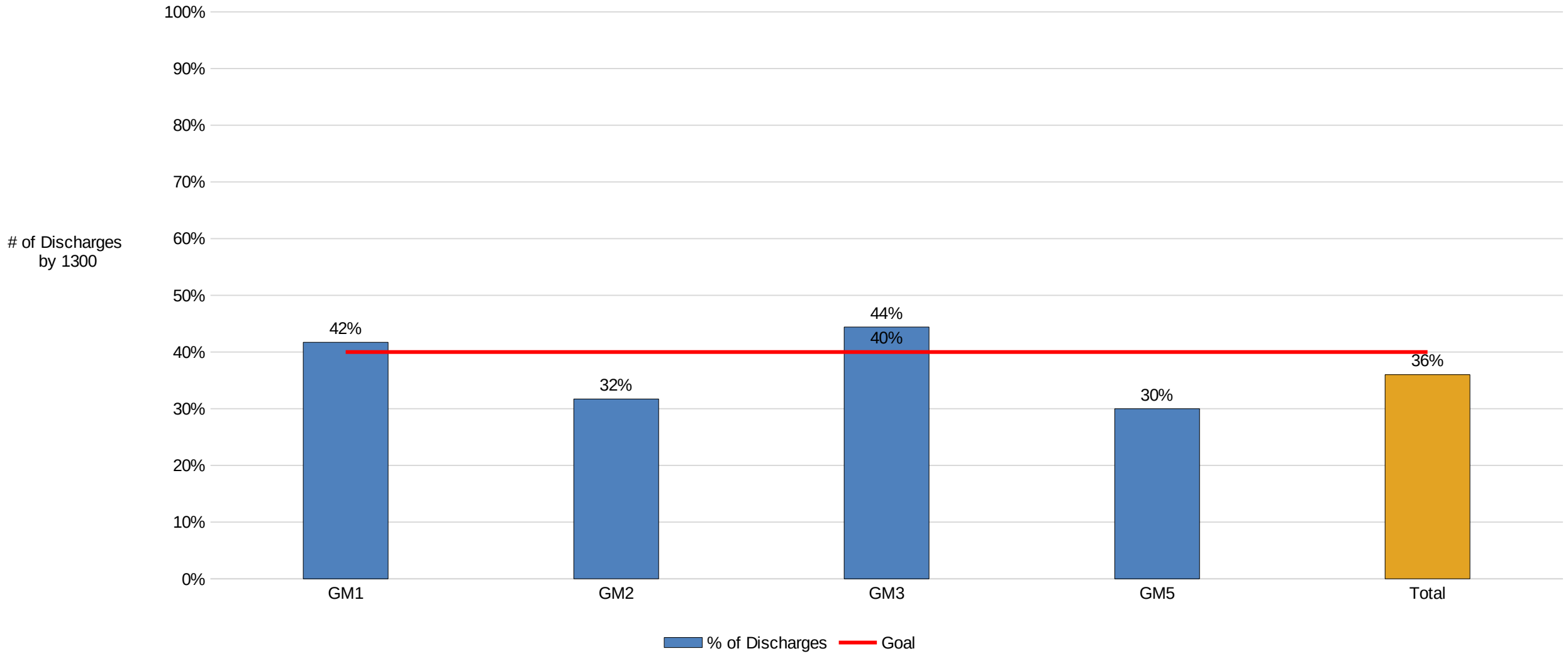


RESULTS - May 2019

- GM1/GM2/GM3/GM5: 5/1-5/31 -

GM3 w/ 2 discharges within 30 minutes of 1300 (52% if dc'd in time), **GM5** w/ 2 discharges within 30 minutes of 1300 (36.5%). **GM2** w/ 5 discharges within 30 minutes of 1300 (44%), **GM1** w/ 1 discharges within 30 minutes of 1300

Discharges by 1300 - May 2019
GM1/GM2/GM3/GM5

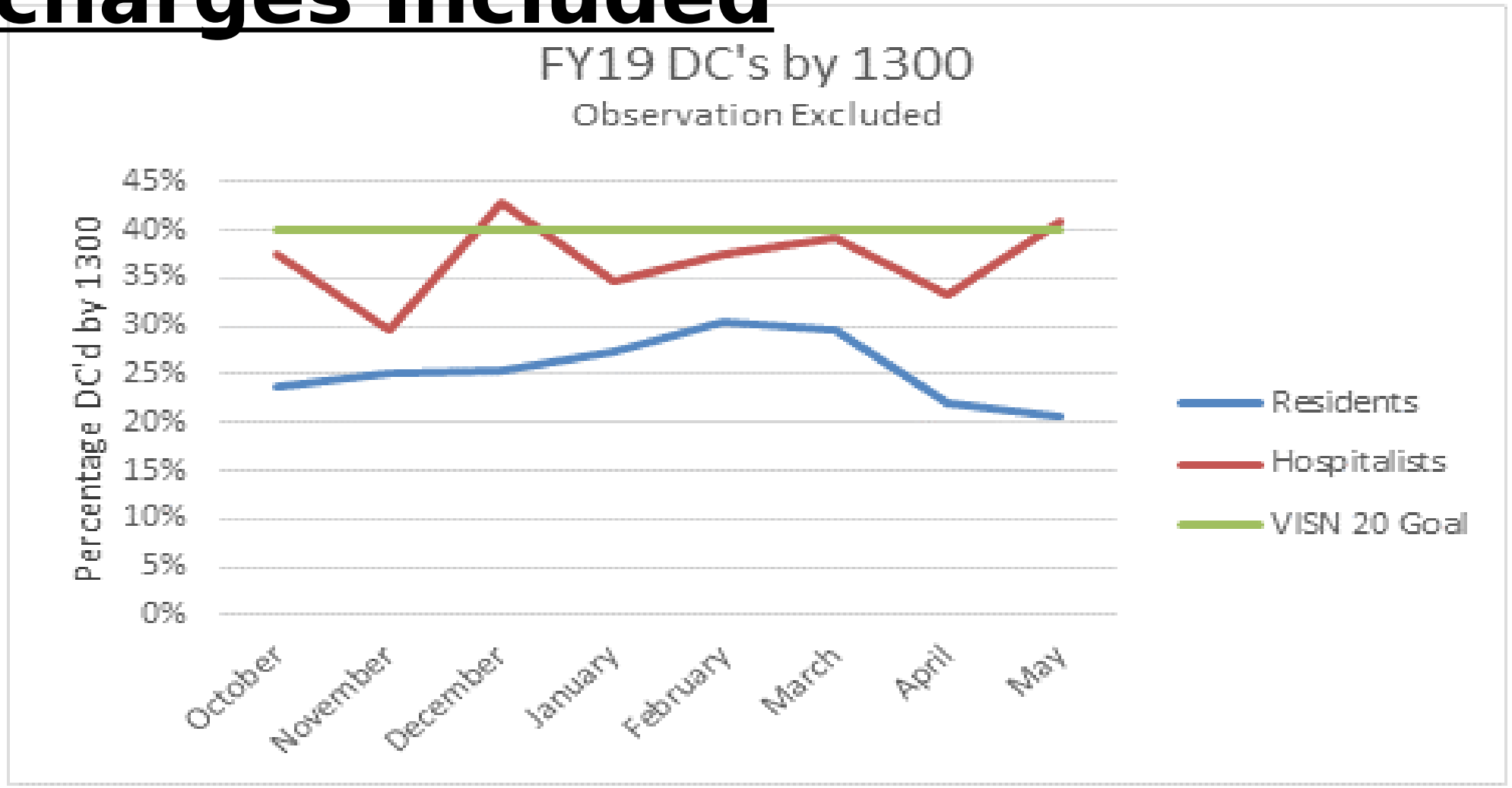


Pilot Data Exclusion

- Sunday/Monday discharges due to no meeting, regardless of meeting target discharge time or not.

- Additional days that intervention did not occur due to:
    - SW unavailability
    - Lack of MD participation

Discharges by 1300 – All GM/CHS Discharges Included



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2019 February-May DC Times

DC Hour	General Medicine	Metabolic	Total
7	0	2	2
8	1	1	2
9	5	11	16
10	16	27	43
11	47	59	106
12 Target DC Time	81	65	146
13 Peak DC Hour	120	89	209
14	109	57	166
15	87	54	141
16	63	39	102
17	43	21	64
18	19	7	26
19	5	2	7
20	1	1	2
21	0	1	1
Grand Total	597	436	1033
DC by 1300	150	165	
Rate by 1300	**25%**	**38%**	**30%**

Length of Stay Data

FY17 and FY18 ALOS

Discharge Specialty	2017	2018	Grand Total
GENERAL(ACUTE MEDICINE)	5.2	5.4	5.3
METABOLIC	5.2	5.6	5.4
Grand Total	5.2	5.5	5.3

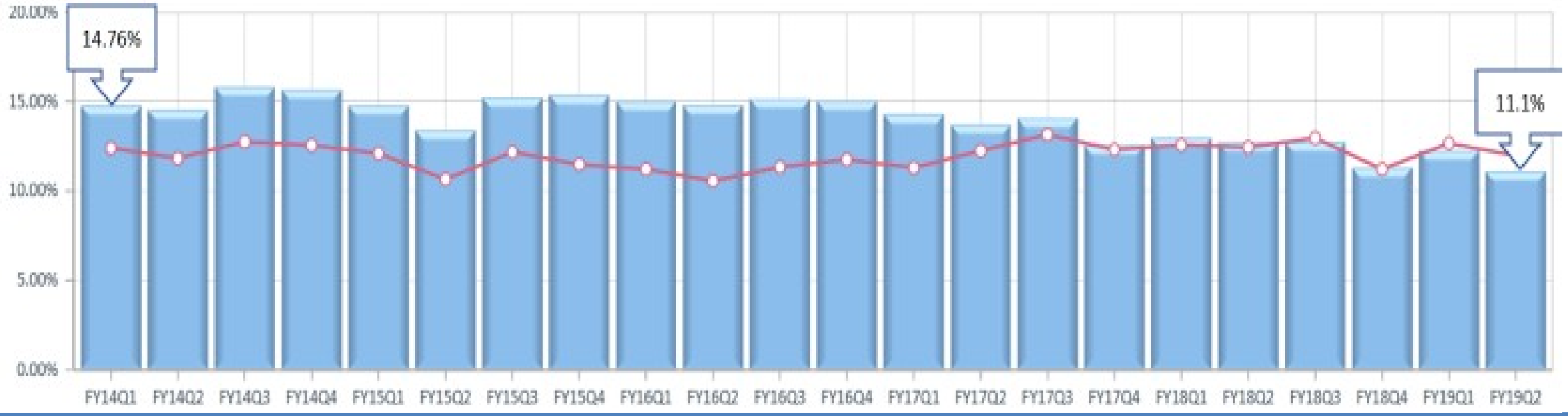
February- May 2018 ALOS

Treating Specialty	Discharges	ALOS
GENERAL(ACUTE MEDICINE)	716	5.4
METABOLIC	389	6.0
Grand Total	1105	5.6

FY19 YTD		
	Avg DCs/Month	Average LOS
General Medicine	155	5.7
Metabolic	100	6
Medicine Total	127	5.8

Readmission Rates

	FY 18	FY19YTD	Feb-May 18	Feb - May 19
Readmits GM&CHS	1039	597	336	304
All Admits GM&CHS	5229	3522	1743	1716
	20%	17%	19%	18%
Readmits GM&CHS	1039	597	336	304
All Admits To Hospital	10049	6617	3371	3229
	10%	9%	10%	9%



Financial Implications

Direct costs of a bed at the VA/day (excluding indirect costs associated w/ having room/bed/hospital maintenance) = $2309.11

$2309.11 / 24 hours = $96.21/hour

FY18: 4402 unique medicine discharges

Target DC Time: 40% of discharges before 1300

Savings if DC time decreased by 1 hour/medicine patient (from peak DC hour target DC hour) - 4402 x 96.21 x 0.40 = $169,406.57

CHALLENGES/LIMITATIONS

- No designated meeting time each day– difficult to coordinate
- Lack of consistent participation/compliance with intervention
- Ineffective communication
- Not enough UM coverage to attend/coordinate all meetings every day of week
- Timing of AM multidisciplinary meeting – narrow DC window.

RECOMMENDATIONS

- Scheduled time and location for meeting in PM.
- Earlier patient rounds/shift multidisciplinary meeting to afternoon only.
- Continued staff education on importance of earlier dc’s
- Consistent weekend meetings/coverage

ACKNOWLEDGEMENTS

General Medicine –
- Interns/Residents/Attendings
- Social workers
- Pharmacists

5D/6D/8D/9C/9D Staff Nurses, MSAs, and Managers

Tracy Trieu

Alice Avolio

Shona Hunsaker

Molly Archer

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QUESTIONS & DISCUSSION