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Development of a Complex Discharge Process

Authors

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Background

Northwestern Memorial Hospital is consistently at high capacity, causing long wait times in the Emergency Department and potential delays in care for those waiting for a bed. One of the drivers of the capacity constraints is patients who remain inpatient past their clinically indicated discharge date. In particular, patients with complex discharge barriers (such as psychosocial, clinical, and financial barriers) often extend the length of stay beyond what is clinically necessary. Therefore, a complex discharge process was developed to decrease avoidable inpatient days and support the hospital's throughput efforts.

Objective

Design and implement a reliable method to proactively identify patients who may have complex discharges and a process to improve timely transition to the next level of care for those patients.

Planning/Research Methods

A multi-disciplinary team of Social Work, Medicine, Nursing, Financial Counseling, Legal, Revenue Cycle, Ethics, Utilization Management, and Performance Improvement was assembled to review the existing structure and develop a complex discharge process. The team used the DMAIC improvement methodology to guide the project:

- Define: drafted charter and assembled team
- Measure: created high level process map, worked to identify data source for baseline data, and updated charter to incorporate data measurement tool into intervention
- Analyze: completed detailed process map, analyzed process and data to understand barriers to timely discharge and placement, and hosted Rapid Improvement Event to identify solutions
- Improve: convened subgroups to further develop interventions identified above, implemented changes, and measured progress
- Control: built sustainment plan with the complex discharge social workers and the social work manager that includes key metrics to monitor progress

Implementation Methods

Three primary interventions were developed by the multidisciplinary team:

- Two complex discharge team social workers, who prioritize complex patients, coordinate with leadership and community resources as needed, and house resources and tips in a complex discharge toolkit
- A report to proactively identify patients who may have complex discharge and placement needs based on an algorithm that incorporates psychosocial, clinical, and financial triggers
- An escalation pathway to ensure all appropriate parties are informed and involved in decision-making related to placement needs for these patients

Results

Decreased average length of stay for complex Northwestern Memorial Hospital inpatients by 22.4 days and average avoidable days for those patients by 21.2 days (results from May 2017-November 2017 compared to baseline period of October 2015-May 2017). The annualized length of stay reduction is 2195 days, the equivalent of adding 6 beds, helping to address the inpatient capacity constraints.

Contact

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