Decreased Length of Stay via Multidisciplinary Discharge Planning

**Purpose**

The goals of this project are to create a standardized MDR process that will be followed throughout the inpatient floors and will be consistently attended by all necessary disciplines providing for a seamless transition of care from the inpatient setting to post discharge. As a result, this will reduce LOS and potentially improve readmission rates.

**Background**

- Cooper University Health Care's inpatient floors lack a consistent and standardized MDR.
- As a result, there is inconsistent attendance and activities related to review and the discharge process.
- The result is a potential regulatory risk, increased length of stay (LOS), increased risk of hospital-acquired infections, and a potential negative impact on service access.

**Analysis**

Team held a workshop with nurses, managed care staff, medical informatics, nursing leadership, and work, physician leadership, information technology, and modified processes.

From this workshop, the team identified issues related to discharge rounds and the transition of care for our patients.

**Learning Objectives**

- Enhanced understanding and adherence to practice policies related to discharge planning.
- Developed a shared vision of discharge planning for our patients.
- Developed a multidisciplinary care planning tool that streamlines the discharge process.

**Process**

1. Each inpatient unit conducted MDR differently and at varying times of the day.
   - Created a designated period for MDR rounds where a System Administrative Manager (SAM) and Medical Director lead rounds for each unit at set times for each unit daily.

2. Inconsistent structure, roles, and rounding process.
   - Established consistent roles for each of the multidisciplinary team members and established a consistent rounding process to be followed at each unit.

3. Inconsistent attendance by MDR participants and inability to efficiently track attendance.
   - Developed an electronic attendance tracking system with real-time capability within TEPs.

4. Current workflows were inefficient and problematic for MDR teams to easily manage the discharge process for our patients.
   - Created a daily multidisciplinary rounds discharge worksheet.
   - Streamlined and centralized the information needed for discharge.
   - Developed a discharge overview summary.
   - Developed an electronic workbook for Social Work and Home Care

**Outcome**

- Reduced LOS.
- Improved patient satisfaction.
- Improved staff satisfaction.

**Year 1 Length of Stay**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Pre-Metrics</th>
<th>Post-Metrics</th>
<th>Statistically Significant?</th>
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<tbody>
<tr>
<td>LOS</td>
<td>Pre: 9.07</td>
<td>Post: 7.85</td>
<td>Yes</td>
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<tr>
<td>P3</td>
<td>Pre: 2.69</td>
<td>Post: 2.31</td>
<td>Yes</td>
</tr>
<tr>
<td>P3.07</td>
<td>Pre: 3.62</td>
<td>Post: 3.12</td>
<td>Yes</td>
</tr>
<tr>
<td>P3.1</td>
<td>Pre: 2.69</td>
<td>Post: 2.31</td>
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**Year 2 Length of Stay**

<table>
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**Opportunity**

- In coordinating care within the Transitional Care Department, it was noted that there was neither a standardized tool to track MDR participants or attendance.
- Documentation by our department focused on discharge summary, but not in narrative form, making trends impossible to track.
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Cooper Medical Informatics
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