Interdisciplinary Discharge Improvement Process within Acute Rehabilitation Hospital

SPAULDING REHABILITATION NETWORK
MGH INSTITUTE OF HEALTH PROFESSIONS
A graduate school founded by Massachusetts General Hospital
CLINICAL SCHOLARS PROGRAM

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BACKGROUND

The Stroke Program at Spaulding Rehabilitation Hospital, in comparison with Regional and National UDS data, has a longer length of stay (LOS) and lower discharge to home rate.

PURPOSE

The Stroke Program sought to improve the overall discharge process by increasing the percentage of patients discharging to the home, while managing length of stay and maintaining excellent patient outcomes and satisfaction.

AIM= To increase discharge to home percentage for stroke patients from 57% to 70% and decrease average length of stay from 19 days to 17 days while maintaining patient satisfaction with discharge planning.
*Existing UDS regional data (69% average home disposition and 16.6 average LOS for home discharge) was used as a goal target.

Discharge Improvement Process Map

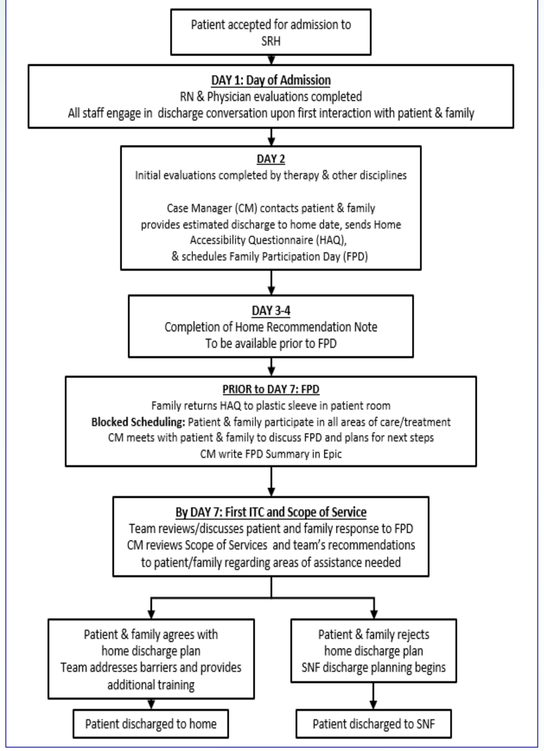

Figure 1

INTERVENTIONS

The Stroke Program formed an interprofessional Implementation Team (The Team) to define workflows and interventions (*Figure 1*). The Team mentored clinicians, reviewed data and implemented tests of change.

Interventions Implemented:

- **Discharge discussions** by team members upon admission.
- Estimated **discharge date provided by day 2** by the Case Manager.
- **Standardized email** to families outlining the purpose and details of **Family Participation Day** (FPD) (Figure 2).
- FPD completed in the first week.
- **Safety Recommendations** amended using plain language (Figure 3).
- Updated **home accessibility questionnaire** (Figure 4).
- Modified **Scope of Service** outlining services, goals and anticipated discharge date (Figure 5).
- Improved the structure of **Interdisciplinary Team Conference** (ITC).

Hello ____,

Thank you for taking the time to connect on the phone. This email is to confirm that you are scheduled for family participation day on the following day/time:

Date:
Time:

Anticipated discharge date:

What to expect: The purpose of this visit is for you to meet with your loved one's medical team, therapy team, and Care Manager to help prepare for discharge home. You will have the opportunity to participate in therapy sessions and discuss recommended assistance and equipment at home. In advance, we ask that you complete the attached home accessibility questionnaire to ensure safety and accessibility for discharge home.

Instructions: Spaulding Rehabilitation Hospital is located at 300 First Avenue, Charlestown, MA 02129. Please park in the parking garage location below the hospital and take the elevator to the main lobby. You will need to check in at the front desk to complete covid-19 screening. Following check-in, you will be directed to your loved one's room and the Spaulding clinician will meet you there.

What to bring:

- Completed home accessibility questionnaire
- Photos on your cell phone of the patient's home layout including stairs, doorways and bathroom

Our Strength Book is also attached to this email. The Strength Book is an overview of what patients/families can expect from their time at Spaulding. It defines the care team's roles, provides overview of the daily routine in the hospital, reviews visiting guidelines and offers supportive materials concerning falls, skin care, emergency preparedness.

Please reach out if you have any questions, we look forward to seeing you.

Figure 2

RESULTS

	2019	Goal	2021
Average Home Discharge Disposition	57%	70%	70%
Average Length of Stay for Home Discharges	19 days	17 days	16.9 days
Patient Satisfaction with Discharge Process - SRH	75*	Maintain above NRC national benchmark of 55	72

Table 1 *data from NRC reflects mid-2020 as baseline

Recommendations for your loved one at the time of discharge:

{SRH safety levels:51199}

- Can never be alone, will need frequent physical assist
- Can never be alone, will need frequent check-ins for safety
- Can be left alone for 2-4 hours once personal needs met, meals and/or toileting set-up
- Can be left alone overnight with proper set-up, will need assistance throughout the day
- Can be left alone day and overnight, but will need help for heavy chores and/or complex tasks
- Can be left alone day and overnight, no safety concerns

Figure 3

SPAULDING REHABILITATION HOSPITAL
300 First Avenue Charlestown, MA 02114 617.952.5000 www.spauldingrehab.org

Home Accessibility Questionnaire

Patient name and room #:

Please complete this form within two days and email to: _____

Please circle the equipment you have available to use at home: (see page 3 for reference)

Wheelchair | Rollator | Rolling Walker | Cane (single point or quad) | Crutches | Raised Toilet Seat
Commode | Toilet Safety Frame | Grab Bars (Toilet) | Grab Bars (Shower) | Shower Chair | Tub Transfer Bench

Please provide the following information about *the home the patient will be discharging to* and **include pictures of the toilet, shower/tub, stairs inside home, and stairs to enter home:**

Home entry:
Primary entrance
- Number of steps to enter the house: ____
- Height of each step: _____ inches
- Railing going up (circle): Right Left Both None
- Doorway width: _____ inches; door swings (circle): In Out
- Is there a sharp turn after entering through the doorway? Yes No

Secondary entrance (if applicable)
- Number of steps to enter the house: ____
- Height of each step: _____ inches
- Railing going up (circle): Right Left Both None
- Doorway width: _____ inches; door swings (circle): In Out
- Is there a sharp turn after entering through the doorway? Yes No

Bedroom:
- Bedroom doorway width: _____ inches
- Bed height: _____ inches
- Floor surface (circle): Carpet Hardwood
- Is there a sharp turn after entering/exiting through the doorway? Yes No

pg. 1

Figure 4

Services to Be Provided and Anticipated Discharge Plan
Goal of care: Discharge to Home
The overall goal of rehabilitation is to improve your ability to function in daily tasks and reintegrate into the community. Your rehabilitation team will help you address the challenges and functional limitations following your injury using a combination of exercise, education, and training sessions.

By the time you leave Spaulding, your team anticipates that you will require the following **supports**/resources to continue your recovery at the next level of care:
- Communicating your needs
- Taking medications
- Daily self-care (getting dressed, bathing, using the bathroom, eating and drinking, continence)
- Household chores (cleaning, laundry, food shopping, bill paying, preparing meals)
- Moving around your home (stairs, walking or using as wheelchair, getting out of bed or a chair)
- Getting into and out of your home
- Transportation/driving and getting around the community

Your rehab team will be considering and working with you on these possible **equipment** needs:
- Wheelchair
- Walking device
- Bathroom equipment
- Communication aids

Your rehab team will be assessing the need for potential home modifications; we will discuss this with you during an upcoming education session.

Expected Discharge Date and Time
Apr 8, 2022

Figure 5

Quotes from families:
"The day was a very positive experience! It was good to see how much she still needs rehab and will continue to need it when she goes home."

"It was informative, good to visualize what he could do. Nice to take that amount of time with my husband and see the progress instead of just talking about it."

OUTCOMES

See Table 1

- Average discharge to home increased from 57% to average of 70%
- Average LOS decreased from 19 to 16.9 days for home discharges.
- Remained above the national benchmark for patient satisfaction with discharge process.
- 96% of survey respondents indicated FPD improved understanding of the rehab process (Figure 6).

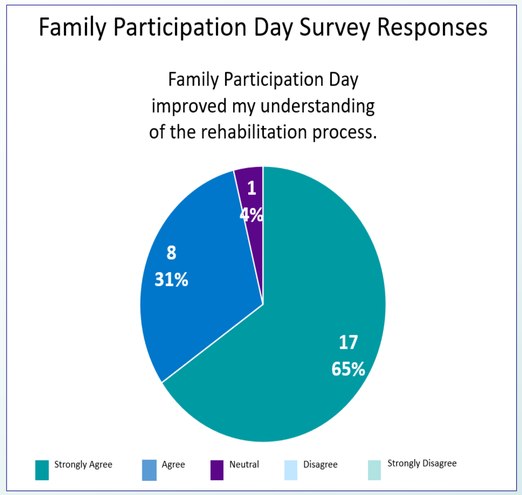

Figure 6

CONCLUSIONS

- Increasing percent of home discharges and simultaneously decreasing length of stay was achieved.
- Timing of discharge discussions and early family participation positively impacted preparedness for home discharge.
- Interprofessional engagement was crucial for success.
- This project is being expanded to other units.

REFERENCES

1. NRC Health Reports. https://nrchealth.com/.
2. Uniform Data System for Medical Rehabilitation, https://www.udsmr.org/.

*The author would like to gratefully acknowledge the SRH Stroke Rehabilitation, Hospital Leadership and Implementation Teams for their consistent hard work and dedication to excellence in patient care.