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Executive Summary

The growing demand for cardiac surgical services, combined with limited inpatient capacity, has focused efforts on improving the discharge process and reducing the length of stay within the cardiac surgery unit of the University of Michigan Health System's (UMHS) Heart Care Program. Currently, patients remain in the Operating Room (OR) or Thoracic Intensive Care Unit (TICU) longer than necessary because not enough beds are available in the general care unit (4C).

This project focused on reviewing the discharge process from general care to home for non-emergency, uncomplicated valve and coronary artery bypass cases. The objective was to synchronize elements of care and communication between providers to reduce the impact of delay and increase the quality of patient care. Reducing the delay in the discharge process will lead to increased bed utilization and patient throughput.

Our project team used a variety of methods to gather data and information leading to our recommendations. These methods include:
- Literature search
- Observations and interviews of key faculty and staff in the discharge process
- Analysis of the system to develop a current state flow chart
- Data collection from the patient
- Interview with staff from St. Joseph Mercy Hospital

Based on these methods of data collection, the project team identified the primary sources of delay, which include:
- Lack of documentation
- Vague task assignments in the discharge process
- Lack of communication between care providers
- Inefficient mechanisms for patient education
- Lack of emphasis on expected discharge date
- Untimely arrangements for transportation home
- Unavailable openings in extended care facilities
- Delayed lab results, medications, and wheelchair arrivals

To reduce these delays and increase quality of patient care by improving process flow, our project team developed the following recommendations:
- Use a discharge checklist that incorporates all of the steps necessary for a patient to be discharged. This checklist indicates the primary person responsible for completing for each step and those who are not certified to complete the task. The checklist will provide documentation that each step was completed and by whom, as well as show the patient status in the discharge process.
- Display the expected patient schedule and discharge date in the patient's room, either on the wall or in a frame near the patient's bed. This will give the patient a better understanding of the steps involved in their discharge and allow them to be more prepared, both mentally and physically, to go home.
- Standardize patient education to ensure patients receive all the necessary information needed during and after their hospital stay. All information sheets and booklets should be provided in one folder, limiting confusion and ensuring that the necessary materials are available. Also, creating an education training video will provide consistent education for each patient.
Introduction and Background
The care providers in the University of Michigan Health System’s (UMHS) Heart Care Program perceive delays in the discharge process. With the growing demand for cardiac surgical services and limited inpatient capacity, streamlining the movement of patients from the Operating Room (OR) to the Thoracic Intensive Care Unit (TICU) to the general care unit (4C) and finally home is critical. Currently patients often remain in the OR or TICU for longer than necessary because there are not enough beds available in the general care unit. This project reviews the discharge process for patients going from general care to home and identifies ways to facilitate patient movement. The recommendations will increase the quality of patient care and reduce delay, ultimately shortening the discharge process and increasing bed utilization.

Approach and Methodology
The team gathered data and internal perceptions regarding causes and significance of discharge delays through the following methods:

- Conducted search for literature pertaining to discharge processes.
- Observed PAs’ and RNs’ daily routines in the 4C unit to see the entire process and witness delays or waiting periods in patient discharge.
- Interviewed faculty and staff members to obtain internal perspectives concerning delays and communication issues. See Appendix A, Interview and Observation Summary.
- Observed morning bed briefing to understand the flow of information between units concerning open beds and how patients are assigned to rooms.
- Collected data from patients through a data collection form to follow patient’s stay in cardiac surgery as shown in Appendix B, Cardiac Discharge Data Collection Form, and by talking with patients.
- Created a current state flow chart of individual discharge tasks based on our observations and interviews.
- Collected time study data for when discharge orders were written and when the patient was discharged.
- Interviewed Jaelene Williams, senior clinical specialist in the cardiac surgery department at St. Joseph Mercy Hospital, to investigate other approaches to discharge planning and understand community standards.

Current Situation
The institutional goal for time of discharge is 11 a.m. However, many of the departments, including the 4C general care unit, are not presently meeting this goal as seen in Figure 1 on the following page. While the unit is discharging its patients earlier than most of the other units in the hospital, there is still a push to reach the 11 am goal. As a result of delayed discharge, beds are not available in 4C for patients moving from the TICU to the general care unit. A backlog of patients in the OR can result.
The congestion of patients is expected to worsen as the demand of cardiac surgery cases continues to increase. Figure 2 shows the increasing trend in number of cardiac surgery cases UMHS has experienced over the past four years.
In a recent audit to prepare the unit for a Joint Commission on Accreditation of Healthcare Organizations evaluation, several key issues were found that impact the discharge process, including a lack of interdisciplinary documentation and standard patient education. These issues are critical because of vaguely defined roles of each care provider in the discharge process. What steps need to be completed in the process and who is responsible is often unclear. As a result, steps are delayed and sometimes duplicated. These delays and duplications increase the workloads of staff members and cause the patient to spend unnecessary time in the 4C unit.

**Analysis**

To analyze the current situation and recommend improvements, our team collected data on the time the discharge order was written and the time that the patient was actually discharged. This data indicates the amount of time a patient waits after the clerk has processed the discharge order. The results from 29 samples in the time study are in the Table 1 and depicted in the current state flow chart.

<table>
<thead>
<tr>
<th>Time Discharge Order Written</th>
<th>Time of Departure</th>
<th>Patient Wait</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>10:43 AM</td>
<td>12:57 PM</td>
</tr>
<tr>
<td>Std Dev</td>
<td>140 min</td>
<td>113 minutes</td>
</tr>
</tbody>
</table>

*Table 1. Time Between Discharge Order Written and Discharge*

On the average, the clerk does not receive the discharge order until 10:43 am, only 17 minutes before the target discharge time of 11 am. This short time span is not sufficient for the subsequent processes to be completed.

Our team verified that the average discharge time from the sample was representative of the system by looking at the median discharge times for 4C between April and July 2000. Our sample fell within 3 standard deviations of the average for that period as shown in Table 2, confirming the validity of our sample.

<table>
<thead>
<tr>
<th>Median Discharge Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 month Average</td>
</tr>
<tr>
<td>3 Standard Deviations</td>
</tr>
<tr>
<td>Project Sample Data</td>
</tr>
<tr>
<td>Unit</td>
</tr>
<tr>
<td>4C</td>
</tr>
</tbody>
</table>

*Table 2. Comparable Discharge Data*

In addition to speaking with Jaelene Williams and learning more about the discharge process at St. Joseph Mercy Hospital, we also compared the average length of stay for cardiac surgery patients at the University of Michigan Hospital to patients at other hospitals. Figures 3 and 4 on the following page show the Average Length of Stay (ALOS) for Coronary Artery Bypass Graft (CABG) operations at area hospitals and university hospitals. When compared to both groups, the University of Michigan falls near the middle. This shows that there is still room to improve the length of patients’ stay at the University. One way a decrease in length of stay can be accomplished is by reducing delays in the discharge process. Reductions in length of stay caused by a more efficient discharge process may not be reflected when length of stay is measured in days, but will be reflected if ALOS is measured in hours.
Figure 3. Average Length of Stay for CABG patients at local hospitals

Figure 4. Average Length of Stay for CABG patients at university hospitals
Current State Flow Chart Analysis

After TICU patient arrives to 4C

Patient goes to clinic appointment requested by unit host or clerk

Request email to STC outpatient clerk

Outpatient clerk returns appointment time to 4C by tube

Discharge Orders are written 10:43am ± 140 min

Patient receives Rx, RTC appointment, and Discharge instructions

Patient Discharged to home 12:57pm ± 113 min.

Average Patient Wait: 2 hr, 14 min ± 83 min

When does patient education begin on diet training, physical therapy, and prescriptions?

When are prescriptions and wheelchair ordered? When are Home Care arrangements made?

Is patient prepared to go home physically and mentally? Is transportation available?

Figure 5. Current state flow chart
Based on initial interviews and observations, our team developed the current process flow chart seen in Figure 5 on the previous page. Faculty and staff verified this flow chart as a good representation of the discharge process that occurs on the 4C unit. The process of discharging a patient is currently viewed as a single, sequential system that is highly dependent on the discharge orders being written. The flow chart above indicates numerous steps in the patients’ discharge are missing. No references to patient education, ordering of prescriptions and wheel chairs, discussion of post discharge care with patient, or home care arrangements are included in the current state flow chart.

Findings and Conclusions
Through the analysis of the current situation our team has identified the following four areas for significant improvement:

- **Clarity of Discharge Steps**
  The future state flow chart of the discharge process emphasizes the tasks that need to be accomplished for a patient to be discharged from 4C. The emphasis on these parallel processes identifies the order in which tasks can be accomplished. Currently, the sequence of the individual tasks is unclear. All of the tasks identified in the flow chart are being accomplished, but not in the most efficient manner. Steps that occur independently of the discharge orders are not started as soon as possible. Postponing these tasks until the discharge orders are written causes delay in the patient’s discharge. The flow chart shows the eight independent process flows that need to occur before the patient is ready to go home. The tasks prior to ‘Discharge Orders Written’ can be done at any time during the patient’s stay in the 4C unit. These processes include aspects of patient education and arranging post-discharge care. Based on our observations and discussions with the care providers in the cardiac surgery department, an improved flow chart was developed that incorporates all steps required for a patient to be discharged. See Appendix C, *Improved Discharge Process Flow*.

- **Discharge Documentation**
  Due to lack of uniform documentation, the care providers cannot go to one location to determine which tasks have been completed, which tasks remain, or who is responsible for each task in the discharge process. Currently, care providers must search the chart for individual pieces of information pertaining to the discharge steps, or they must locate the proper care provider to determine the needed information. As noted earlier, all of the essential discharge steps are being completed; however, because no documentation exists, when and by whom these steps are accomplished is unknown. The lack of facilitated communication between care providers leads to tasks being duplicated and a longer patient stay.

- **Emphasis on Patient’s Discharge Date**
  The date of discharge needs to be the focus of each patient’s stay in the general care unit. Presently, the patients may not be told they are going home until the morning of discharge, leading to many delays in getting the patient ready to leave the hospital. The patient’s family has little time to arrange transportation home, and may not be able to arrive by the institutional goal of 11 a.m. for discharge time. Also, a delay in the discharge may occur because the patient is not mentally
prepared to leave. The criteria that must be met and what tasks must be accomplished before the patient is ready to leave the hospital is often unclear to the patient. If discharge comes as a surprise to patients, they may feel insecure about leaving since they are not aware they have already met the discharge goals. The lack of time before notifying the patient of the discharge date leads to a delay in waiting for transportation and mentally preparing the patient to return home.

- Patient Education Mechanisms
  Currently, no standardized method of teaching patients the necessary information after heart surgery exists. The patients are given a series of educational materials beginning with the Heart Surgery Information Booklet, which they receive when they enter the pre-operative clinic. Additional pamphlets and papers lead to confusion for both the patient and care provider. A second delay occurs because some of the education material is unavailable. Often the patient forgets to bring the Heart Surgery Information Booklet on the day of surgery because its importance is never emphasized. Also, patient education on prescription drugs can cause a delay because the VCR on the unit is often unavailable for use. Sometimes only one VCR works on the entire floor. The lack of materials causes the patients to wait for the training and allows for duplication of many educational aspects.

Recommendations
To execute the improved process flow demonstrated in the future state flow chart, we recommend three improvements—using a discharge checklist, posting the expected patient schedule and discharge date in each room, and standardizing patient education. Each improvement will lead to a more efficient discharge process and a higher level of patient care.

- Begin Using Discharge Checklist
  We have developed, with the help of the care providers on 4C, a list of all the tasks that lead up to patient discharge. We have also identified who is able to complete each step and a single caregiver who has primary responsibility for the completion of each step. This information has been incorporated into a checklist shown in Appendix D, Cardiac Surgery Discharge Checklist. This checklist should be incorporated into the patient’s chart so that any care provider can readily identify what tasks need to be completed for a patient. Further, it will enable care providers to determine whose assistance is necessary to complete the remaining tasks.

- Display Expected Patient Schedule and Discharge Date in Rooms
  To mentally prepare the patients to be discharged, we recommend displaying a tentative discharge date and expected patient schedule in the patient’s room. Refer to Appendix E, Expected Patient Schedule. This schedule will encourage the patients to focus their energies on being ready to go on the proposed date. Such preparation can include arranging for transportation home or to an extended care facility and preparing questions for the care providers about what to expect as recovery continues at home. The schedule will also inform patients of the goals
that must be reached before discharge. The expected patient schedule should be placed in a standard area where it is visible to the patient and encourages discussion with providers.

**Refine and Standardize Patient Education Methods**

To ensure that each patient receives the appropriate education, we recommend refining and standardizing the education process. First, all of the resources needed to properly educate the patients must be available. Patients receive the *Heart Surgery Information for Patients and Their Families* booklet in the pre-op clinic, and are expected to bring it back when they return to the hospital for surgery. However, this reminder is only mentioned in the booklet in one line on page 24. Placing a brightly colored sticker on the cover of the booklet reminding the patient to bring it with them when they come for surgery will increase the chances of the patient arriving with the booklet.

Further, patients who are on Coumadin® are shown a video about the medication. However, during our observations, the VCR used to show the video was broken, so the film could only be viewed on the University television station three times daily. If patients miss one of the times, they have to wait several hours until the next viewing. To remedy this, several VCRs should be available on the unit.

To standardize patient education a patient education video consisting of the general discharge information should be developed to insure that each patient receives the same information from the same source. A video will allow caregivers to spend more time answering patient questions and completing other discharge steps.

Reading the pamphlets onto a cassette tape would allow patients who have trouble reading, have poor vision, or are better auditory learners to receive all necessary information in a more appropriate manner.

**Action Plan**

The following steps are necessary to implement each of the recommendations outlined above:

- **Implement Discharge Checklist**
  - Each care provider involved in the discharge process should be familiar with the discharge checklist. Each staff member should receive a copy of the checklist, and the report in Appendix F, *How to Use the Discharge Checklist*. The material should then be reviewed with the staff at a general meeting where questions can be addressed and common procedures for use agreed upon.
  - The checklists should be included in each patient’s chart. When care providers complete one of the tasks on the sheet, they should initial in the box for their functional group, and note the date and time the task was completed.
  - Once the patient is discharged the checklist should be retained to verify the completion of all tasks and for use in further analysis.
• A nurse educator or specialist will have an electronic version to make changes as necessary as the process continues.

- Display Expected Patient Schedule and Discharge Date in Rooms
  - The Expected Patient Schedule should be posted in each patient room either on the wall or in a frame near the patient’s bed.
  - When a patient is transferred onto the unit, a Clinical Care Coordinator should review the schedule with the patient. The coordinator can advise them that individual patient treatments vary and that they should not be concerned if they are not following the path explicitly.
  - The Clinical Care Coordinator should also write the tentative discharge date on the form and tell the patient that this date is subject to change.
  - Each day, the Clinical Care Coordinator or another designated care provider, should review the patient’s specific set of goals for the day and note them on the expected schedule.

- Refine and Standardize Patient Education Methods
  - Put all the education materials the patient is given in a folder or envelope. The envelope should be given to the patient upon arrival to the general care unit and include information from other areas such as nutrition and pharmacy.
  - Ensure two VCR sets are available to allow multiple patients to watch medication and general education videos.
  - Develop and place a reminder sticker on the *Heart Surgery Information for Patients and Their Families* booklet. The sticker should be large enough to notice easily.
  - Collect the information to include in the standard education video and investigate production.
  - Read and record the *Heart Surgery Information for Patients and Their Families* booklet onto cassette.

Other options that we considered, but based on further analysis are not recommended for implementation, can be found in Appendix G, *Improvements Considered, but not Recommended*.

By implementing the discharge checklist, posting the expected patient schedule, and standardizing the patient education program patients will experience fewer delays in the discharge process. Such implementations address the issues of lack of documentation, vague task assignments, lack of communication, inconsistent patient education, and lack of emphasis on discharge date and patient completion of necessary tasks. These changes will enable an increase in the quality of patient care, a length of stay closer to the critical path expectations, and more available beds for patients moving from the TICU to the general care unit.
Appendix A: Interview and Observation Summaries

• Velicia Passaro, R.N., Clinical Nurse Specialist
  Velicia was our main support with scheduling interviews and observations with staff. She provided information about the discharge process and all the steps that are necessary for discharge, coordinated with staff on the 4C unit to assist in data collection, and supplemented the team with previously collected data.

• Elise Carlson, PA and Hathy Halabicky, NP:
  Team members observed the physicians assistants role on the 4C unit and received information about causes of delays in the discharge process. The observation period consisted of joining rounds with the physicians, observation interactions with patients, and preparing discharge order forms. They specifically addressed communication delays when locating patient X-rays, receiving patient lab work, and preparing the patient to go home once the discharge order had been written.

• Joy Wallace, R.N., Charge Nurse
  The charge nurse observations aided in determining communication between all units of the hospital and between those involved in the discharge process on 4C. One of the key experiences of this observation was attending a bed briefing to see the coordination between all of the hospital units on the exact number of beds that were needed to accommodate the operating room schedule and where patients were going to be transferred. Our team saw the process for determining which patients will be discharged from the unit, how many patients can be accepted onto the unit, and the types of patients that have higher priority than others. The additional responsibilities of the charge nurse were gathered as well as data pertaining to the communication between care providers on the 4C unit.

• Jan Watts, R.N., Nurse Manager
  Jan stressed the importance of documenting a patient’s education before and after heart surgery. She introduced our team to the Heart Surgery Information for Patients and Their Families booklet and noted the lack of emphasis on its use throughout the patients stay in the hospital. Also, Jan informed the team of the bed briefing that occurs every morning to determine which units have beds available and which units need to transfer patients. This served as a means for the team to determine communication between different units.

• Richard Prager, M.D.
  Dr. Prager recommended that our team meet with all four surgeons in order to understand their perspective. He continuously provided us with benchmarking data from his former place of employment, St. Joseph Mercy Hospital. Dr. Prager stated that the majority of the responsibility on the 4C unit should be with the Clinical Care Coordinators. This would allow for accountability and assurance that all necessary steps in the discharge process were accomplished. He also suggested comparing the various patient types for the length of stay in 4C.
## Appendix B: Data Collection Form

The information collected on this form is being used to improve the quality of patient care at the University of Michigan Health Systems. The data will be grouped for reporting purposes and all patient information will be kept strictly confidential. Please complete as much of the information as possible. Thank you for your help.

**Patient Name:** ____________________  **Date of Surgery:** ____________________

**Surgeon:** ____________________  **Date Moved to 4C:** ____________________

**Room #:** ____________________  **Surgical Procedure:** ____________________

<table>
<thead>
<tr>
<th>Function</th>
<th>Care Provider’s Name</th>
<th>Date Completed</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notified of Discharge (DC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DC Prescriptions Received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DC Prescriptions Explained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Care Arrangements Explained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Medical Equipment Explained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet Training Received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-Up Appointment Scheduled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pink or Green Discharge Sheet Received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Discharge Sheet Received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Sheets Reviewed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check that DC Transportation has been Arranged</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathed and Dressed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Belonging Collected and Returned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair Arrived</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discharge Date:** ____________________  **Time of Discharge:** ____________________

Comments regarding the discharge procedure: ____________________________________________
Appendix E: Expected Patient Schedule

This is a tentative schedule for a patient's stay in the 4C Unit. Individual treatments may vary based on Doctor's orders or patient's condition.

Day 1
- Meet with Clinical Care Coordinator
- Sit up in a chair
- Try to drink liquids
- Learn about medications you will take
- Learn about pulmonary hygiene

Day 2
- Meet with Clinical Care Coordinator
- Consume a completely regular diet
- Review medication teaching
- 3 walks in 4C
- Arrange a ride home for Day 4

Day 3
- Meet with Clinical Care Coordinator
- Receive Dietary Training
- Learn how to care for your wounds
- 3 walks in 4C
- Confirm ride home for Day 4

Day 4
- Exhibit Stable Medical Conditions
- Meet with Clinical Care Coordinator
- Schedule follow-up appointment
- Review discharge instructions
- Review self-medication schedule
- Gather clothing and personal belongings
- Receive test and lab results
- Continue recovery at home!!

Today's Goals

Projected Discharge Date
Appendix F: How to Use the Discharge Checklist

Instructions for the Cardiac Surgery Discharge Checklist

The Discharge Checklist will increase interdisciplinary documentation of discharge task completion. Each patient’s chart should include a Discharge Checklist. Completing the chart will provide an efficient way to determine patient status: what steps have been completed, what still needs to be done, and who can perform such steps.

Checklist Layout

- Patient information is at the top of the sheet. The blank square is for the patient stamp.
- Abbreviations used in the chart are found under the patient information.
- The main steps in the discharge process are listed on the side of the checklist.
- The care provider who is primarily responsible for each step is outlined in bold.
- Care providers who are able to complete the task are in white.
- Shaded care providers cannot complete the task.

Checklist Use

- Before you begin a step, refer to the checklist to make sure that it has not already been completed.
- Ensure that you are able to perform the step (i.e. not shaded).
- When the step is complete, fill in the date and time on the checklist.
- Initial the checklist over your function in the task row.
- Place checklist back in patient’s chart.
## Appendix D: Cardiac Surgery Discharge Checklist

<table>
<thead>
<tr>
<th>Function</th>
<th>Care Provider</th>
<th>Date/Time Finished</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-DC Information Sheets Given to Patient</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Post-DC Procedures Reviewed with patient</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Diet Education</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Medications Explained</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Home care discussed with patient</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Home medical equipment discussed with patient</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Home care arranged</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Home medical equipment ordered</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Verify that Transportation has been Arranged</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Appropriate Follow-Up Appointment Confirmed</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Chest X-Ray Results Received</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>All Labs Results Received</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Discharge (DC) Orders Written</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>DC Prescriptions Written</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>DC Medications ordered (if filled at UMHS Pharmacy)</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Patient Notified of DC</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>DC Forms Completed</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Personal Belonging Collected and Returned to Patient</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
<tr>
<td>Wheelchair Ordered</td>
<td>Dr. Res. APT RN PM CCC CI O</td>
<td></td>
</tr>
</tbody>
</table>

*Providers that have primary responsibility are outlined in bold. Those who cannot perform each task are shaded.*
• Cindy Donaldson, R.N. and Amy Geltz, R.N., Clinical Care Coordinators
  The Clinical Care Coordinators specifically noted that some delay might come from
  conflicting priorities between different care providing groups and wanted to see more
  follow up appointments set when a patient is leaving the hospital. In designing the
  Discharge Checklist, they assigned roles of care providers who would have the lead
  role in accomplishing each task in the discharge process and those to whom the task
  could be delegated. When presenting Amy and Cindy with the expected patient
  schedule, they noted the department’s hesitance to list an exact schedule of patient
  tasks and focused on the need to have patients who deviate from the schedule remain
  calm and not become worried.

• Vanessa Harman, R.N, Senior Practice Management Coordinator
  Vanessa explained the processes and effects of dealing with the patients’ insurance
  companies. Emphasis was on the importance of communication between the clinical
  care coordinators and herself as to the required at home care that is necessary.
  Specifically Vanessa is responsible for patients that need post discharge medical
  attention and making sure that the patients insurance will cover, as far as possible, the
  full extent of the procedure.

• Patients on the 4C Unit
  Our team interviewed patients on the 4C unit in order to determine their feelings
  about the length of stay at the hospital and the speed and quality of the care they were
  receiving. Overall, the patients were satisfied with the quality of the care that they
  were given. However, the patients stressed that there were too many forms given to
  them at many different times, by many different people. The discharge process gave
  the impression of being disorganized because of the large number of people giving
  the patient various informational documents. This information focused our project
  team on the need to standardize the patient education program.

• Jaelene Williams, R.N., Senior Clinical Specialist, St. Joseph Mercy Hospital
  Jaelene provided our team with a perspective of how discharge planning is done at
  other institutions. St. Joseph Mercy has a team of discharge coordinators who are
  responsible for making sure every patient gets everything they need before they leave
  the hospital. They first tell the patients at least one day in advance that they are likely
  to be leaving, then post in the patient’s room a sheet that says “You will be going
  home tomorrow if…” and list the steps that must happen for them to be discharged.
  This allows everyone involved with the patients—the patients themselves, their
  family, and each care provider—to know that the patients are being prepared to be
  discharged. St. Joseph’s also has a video shown to patients before they are
  discharged that covers the important points they need to know before they leave the
  hospital. Jaelene also noted that the discharge coordinator often directly contacts a
  patient’s family to address any questions they have and confirm they will be able to
  take the patient home when the doctor determines the patient is clinically ready. She
  noted that this contact was a very important part of the process because often the
  hardest person to convince that the patient is ready to go home is the patient’s family.