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ANALYSIS OF THE IMPLEMENTATION OF EARLY DISCHARGE PLANNING AT X GENERAL HOSPITAL

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ABSTRACT

The process of treating patients in hospitals generally takes a long time and costs a lot. This can cause various problems, such as overcrowding of inpatient rooms, long queues of patients, and increased health care costs. Early discharge planning (EDP) is a strategy that can be used to reduce the length of patient care and health care costs. The aim of this research is to analyze the EDP implementation process at X General Hospital from March-May 2024. This research method uses descriptive research methods. Data collection techniques in this research are observation, interviews and literature study. The data that has been collected is then analyzed using the univariate method with the help of a fishbone diagram. The research results show that X General Hospital faces a number of challenges in implementing the H-1 discharge planning strategy. Some of the problems identified include lack of uniformity of understanding among doctors in charge of patients (DPJP) regarding the H-1 discharge planning program, lack of DPJP participation in socializing the program, lack of communication standards between patient care officers (PPA) regarding the H-1 discharge planning program to patients and their families, the absence of a policy regarding compensation fees for DPJP on the day the patient is discharged if no visit is made, lack of standardization in communication regarding patient discharge, as well as less than optimal coordination between PPA via telephone or WhatsApp, and also a lack of effective coordination with third parties or guarantors via telephone or email.

KEYWORDS early discharge planning, hospital, planning

INTRODUCTION

The process of treating patients in hospital often takes a long time and costs quite a lot of money. This can cause various problems, such as overcrowding in inpatient rooms, long queues of patients, and an increase in overall health care costs. One strategy that be used to overcome this problem is early discharge planning (EDP).

Discharge planning is a structured process that involves assessment, preparation and coordination to ensure the smooth running of health and social

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services before and after a patient is discharged. This process involves interaction between medical personnel, patients, and families to organize and manage continuity of care after discharge. The focus of planning must be on the patient's needs, including prevention, therapy, rehabilitation and necessary routine care (Agus & Kadir, 2021).

Discharge planning is a crucial aspect of palliative care in hospital, which aims to prepare for follow-up care in the home environment. Patients facing serious illnesses and their families need to receive clear information about the expected prognosis of the disease, ensure optimal management of signs and symptoms, and help identify appropriate treatment goals. Apart from that, psychosocial and spiritual aspects also need to be considered in the planning (Wibowo et al., 2020).

At X General Hospital, there is a trend of increasing demand for VIP services throughout 2024, which is reflected in the quite high percentage of bed usage. In order to manage the continuity of this service, a patient discharge planning program is needed the day before (discharge H-1). This program aims to ensure that the patient discharge process can be planned well, so that the flow of patients in the hospital becomes smoother and reduces the possibility of complaints or problems in the process.

The introduction of the patient discharge planning program one day in advance (H-1 discharge) is expected to have a positive impact on patient confidence in hospital services. So by implementing this program, patients will feel more thoroughly prepared before going home, increasing their confidence in the treatment and discharge process. In addition, it is hoped that this program can also increase bed turnover in hospitals, by reducing long waiting times or delays in the discharge process, thereby reducing the possibility of complaints or dissatisfaction from patients and their families.

Previous research by (Michdar et al., 2021) found that the implementation of Discharge Planning for inpatients at Siloam Hospital Balikpapan had not been running according to the standards set by the hospital, namely 100%. In implementing discharge planning, the most influential factor is the human resources factor, seen from the implementation of the discharge planning cycle from the beginning of HR involvement to the end. It is recommended to the hospital management that the parts that are still inappropriate (14.5%) can be evaluated further, so that the causal factors can be immediately corrected.

Other research by (Wulandari & Hariyati, 2019) shows that 80% of respondents stated that the discharge planning format prepared was easy to understand, easy to implement, not complicated, not long-winded, and practical. Therefore, the management of RS Next, the management needs to provide outreach to the nurses on duty before the hospital implements it.

The novelty of this research comes from the ideas of early discharge planning program Hospital, which has rarely been studied before. The practical implication of this research is that the X General Hospital can use the findings of the analysis of the implementation of early discharge planning as a basis for improving the patient care and discharge process efficiently. The aim of this research is to analyze the EDP implementation process at X General Hospital from March-May 2024.

RESEARCH METHODS

This research method uses descriptive research methods. Descriptive research is a type of research that aims to provide a detailed description or picture of a particular phenomenon, whether natural or man-made. This research does not only aim to analyze or provide an overview of the results of the subjects studied, but is also not intended to draw conclusions or provide broader implications from the findings obtained (Rusli, 2021). Data collection techniques in this research are observation, interviews and literature study. The data used is Early Discharge Planning data at X General Hospital from March-May 2024. The subject of this research is X General Hospital. The data that has been collected is then analyzed using the univariate method with the help of a fishbone diagram.

RESULTS AND DISCUSSION

Discharge is the stage where a patient who has received medical treatment in a hospital or other healthcare facility is deemed well enough to return to their home or other location and continue their healing process there (Galvin et al., 2017). This process involves a thorough evaluation of the patient's condition to ensure that the patient can adapt back to their own environment or to a suitable place for continued recovery. When there is a delay in the discharge of a patient from hospital to home or elsewhere, the impact can be devastating. These can include leading to worse outcomes for the patient, causing distress for the patient and their family, and leading to increased costs for the health system (Landeiro et al., 2019).

Delays in discharge from hospital occur when a person has been medically cleared for discharge to home or another location, but arrangements for transfer and subsequent care are not in place, leading to the patient remaining in hospital. Such delays can stem from several factors, including non-comprehensive assessments when patients are first admitted to hospital, long-standing imperfections in care arrangements, difficulties in accessing follow-up health care and social support, or a lack of effective communication between hospitals and health and social service providers (Bibbins-Domingo 2019). The impact is on the patient as well as on the health facility concerned, such as the hospital which may experience increased burden and costs due to the care of patients who are not matched to their medical needs.

In addition, patients who have elaborate and hastily developed discharge plans towards the end of their hospital stay are at risk of experiencing delays in their otherwise timely discharge. Such plans may be poorly coordinated and fragmented, which may increase the risk of readmission (Holland et al., 2015). Thus, recent trends suggest supporting timely hospital discharge by targeting patients with higher healthcare costs, by strengthening the coordination of hospital-to-home transitions and implementing policies such as early discharge planning for patients, known as early discharge planning (Gonçalves-Bradley, 2022).

Early discharge planning (EDP) is a collaborative process that aims to expedite the safe and effective discharge of patients from hospital (Zhu et al., 2015). The aim of discharge planning is to improve the efficiency and quality of healthcare by reducing delays in hospital discharge, facilitating the transition of patients from hospital to the post-discharge environment, and providing information to patients

regarding the management of their health problems. There is evidence to suggest that discharge planning specific to each patient before they leave the hospital, and combined with additional post-discharge support, can reduce the likelihood of patients having to be re-hospitalized unplanned (Gonçalves-Bradley, 2022).

The early discharge planning (EDP) program has been implemented, one of which is at X General Hospital by utilizing patient discharge planning which is carried out one day before the patient's discharge. This is related to efforts to overcome challenges in bed management in hospitals that have high occupancy rates, as well as the increasing demand for VIP class services by 2024. Therefore, a one-day advance discharge program is needed to ensure that patient discharge can be well planned and patient flow can run smoothly without excessive complaints.

Supported in research (Chhith, 2023), mentioned that h-1 discharge is expected to increase patient confidence and optimize bed usage without generating complaints over long waiting times. This approach is also geared towards improving patient safety and hospital outcomes by facilitating early discharge through multidisciplinary teamwork, which aims to manage patient flow by overcoming barriers to discharge and reducing the duration of hospitalization in medical or surgical units.

A previous study by Fox (2016), showed that nurse-led early discharge planning (DPP) programs were effective in reducing hospital readmission rates by 28%, reducing hospital length of stay by more than 2 days, and reducing mortality by 30% compared to standard care that did not involve nurses in early discharge planning. Nurse-led DPP has also been shown to reduce total costs and hospitalization costs. Based on this, it can be stated that the implementation of EDP can provide significant benefits to patients and hospitals. However, currently, X General Hospital is faced with the challenge of increasing the percentage of h-1 early discharge planning from an initial level of around 20% to 70%.

The EDP implementation at X General Hospital, which was analyzed from March to May 2024, can be shown in Table 1 below:

Table 1. EDP Implementation of X General Hospital March-May 2024

			March		April		May	
No.	Unit	Standar	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
1	Ward A	80%	1	40	40	74	46	105
2	Ward B	80%	0	160	22	123	33	141
3	Ward C	80%	4	53	13	118	17	123
4	Ward D	80%	3	97	6	109	24	147
5	Ward E	80%	28	99	48	80	77	112
6	Ward F	80%	1	95	1	113	14	129
7	Ward G	80%	4	86	9	102	29	104

8	Ward H	80%	3	51	47	81	37	73
9	Ward I	80%	1	95	9	80	18	94
10	Ward J	80%	24	49	29	43	57	70
Total Achievement			69	771	233	923	352	1098
			0.08949416342		0.02524377031		0.320582878	
Numerator	(Number of patient data given H-1 discharge plan instructions)							
Denominator	(Total data of inpatients who were discharged)							

The table provides information on the target standard for EDP implementation, which is 80%, and the numerator and denominator for each inpatient unit per month. The numerator refers to the number of patients given H-1 discharge plan instructions, while the denominator refers to the total number of hospitalized patients discharged. In March, the total EDP achievement was 69 out of 771 patients, which means it reached 0.08949416342 or 8.95%. Whereas in April, it reached 233 out of 923 patients (0.2524377031 or 25.24%), indicating an increase from the previous month. In contrast to May, the total achievement reached 352 out of 1098 patients (0.320582878 or 32.06%), showing another increase compared to the previous months.

These results show that EDP implementation in the three months of analysis is still below the set target of around 80%. Although it has not yet reached the target, the data shows an increase in the achievement rate each month. This indicates that with the right approach and improvement, the discharge process can be optimized and the set target can be achieved.

In this case, to provide an optimal discharge process, effective collaboration between the patient's attending physician, nurses, and other healthcare staff is essential. Such as involving cooperation between doctors to assess the patient's eligibility and safety for discharge, as well as the role of nurses and other medical team members in delivering information and providing education to the patient. In addition, it is also important to pay attention to how doctors and nurses interact with patients, because the way they communicate can affect patients' understanding and readiness to go home (Wiryawan et al., 2022).

The following is an identification of several obstacles related to the non-achievement of the implementation of H-1 discharge planning at X General Hospital, which is presented in the following fishbone diagram:

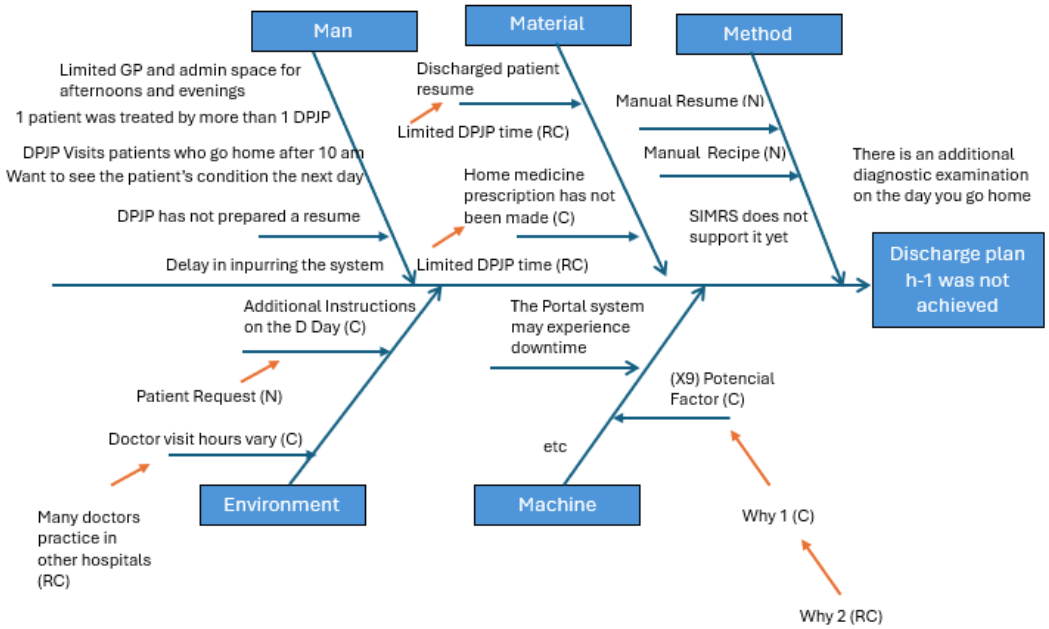

Figure 1. Fishbone Diagram

Based on Figure 1. presents a fishbone diagram that illustrates several obstacles related to the non-achievement of the H-1 discharger plan at X General Hospital which can be identified in several aspects, such as:

1. Human Aspect

Obstacles such as the limited number of general practitioners (GPs) and administrative staff in the night and afternoon ward, some patients are treated by more than one specialist (DPJP), which results in challenges in coordination, DPJP visits to patients who will be discharged are carried out after 10 am, causing delays in preparing patient resumes, DPJPs often do not prepare patient resumes on time, and delays in entering information into the system.

2. Material Aspect

Discharge resumes are often incomplete due to the DPJP's limited time. In addition, the DPJp's limited time also results in delays in making drug prescriptions for discharged patients.

3. Method Aspect

The process of preparing resumes and prescriptions is still done manually, while the hospital medical information system (SIMRS) has not fully supported it. Then, there is also the addition of a diagnosis on the day of the patient's discharge.

4. Environmental Aspect

Several obstacles such as additional instructions given on the day of discharge, special requests from patients, varying doctor visiting hours, and many doctors also practicing at other hospitals, lead to a lack of consistency in the discharge process.

5. Machine Aspect

In the machine aspect, constraints such as the portal system that can experience service interruptions (downtime) hinder the discharge process.

In response to the emergence of these obstacles, an appropriate strategy is needed to improve the implementation of the program. To improve the

implementation of early discharge planning (EDP) and the percentage of H-1 discharge planning from X General Hospital as in the table below:

Table 2. Strategies to improve the implementation of the DH Plan H-1 program

Increase DPJP participation in the H-1 Discharge Plan program	Increase DPJP Visit on H-1 or D-day < 10.00 a.m.	Reporting of the patient's condition on the day of discharge by telephone by the GP to the DPJP
Socialization of policies and education through videos of patient discharge flow and some justifications for the H-1 discharge plan program at committee meetings.	H-1 discharge plan policy related to DPJP visit time and criteria for patients to be discharged in the form of internal memos or letters to all KSMs.	Management policy on DPJP fee compensation
Coordinate with the Chief Medical Officer and Medical Committee to approach the Head of KSM or DPJP in the form of OPPE or Internal Memo	Communication standards of DPJP GP, Nurses related to the delivery of discharge information to patients and families	Designation of GP as PIC of each KSM
		Establishment of regulations related to the person in charge of the patient's condition at discharge through online consultation 1x24 hours the patient is discharged

In addition to socialization, increasing the participation of specialist doctors (DPJPs) in the DP H-1 program can be achieved by coordinating with the Head of the Medical Division and Medical Committee to approach the CBO Chair or DPJP. This approach can be done through Objective Professional Practice Evaluation (OPPE) or internal memos highlighting the importance of the H-1 DP program and the active role of DPJPs in the process.

The second strategy to improve H-1 discharge planning at X General Hospital is to increase specialist visits (DPJP) on day H-1 or before 10.00 WIB. This approach can be realized through the issuance of policies related to the H-1 discharge plan which includes the time of the DPJP visit and the criteria for patients who are eligible for discharge. This policy can be drafted in the form of an internal memo or letter addressed to all CBOs (Chief Medical Staff) and formally implemented in the hospital.

In addition, improving DPJP visits in optimizing discharger planning can also be done by establishing clear communication standards between specialist doctors (DPJP), general practitioners (GP), and nurses regarding the delivery of information to patients and their families who will be discharged. Communication standards should contain clear procedures that can be implemented consistently throughout the hospital. These communication standards should define the responsibilities of

each party, including when and how information regarding the patient's discharge is delivered to the patient and their family. For example, DPJPs should provide relevant medical information, GPs can provide guidance on follow-up care, while nurses are responsible for providing practical instructions to patients and families on home care. By establishing clear communication standards that can be implemented consistently, it is hoped that information conveyed to patients and their families will be more structured and directed, thereby minimizing confusion and improving patient preparation for discharge.

The third strategy to improve H-1 discharge planning at X General Hospital involves reporting the patient's condition on the day of discharge via telephone by the general practitioner (GP) to the specialist doctor (DPJP). The GP should report the patient's condition on the day of discharge by phone to the DPJP to ensure the readiness and safety of the patient's discharge. This strategy can be realized by first, establishing a fee compensation policy for DPJPs as an incentive to ensure their active involvement in discharge planning. The provision of compensation makes it likely that DPJPs are more motivated to engage and give the necessary attention to the patient's condition on the day of discharge. As a result, DPJPs will be more likely to receive and respond to reporting from GPs more seriously and effectively, improving the safety and success of the discharge process.

The second point involves implementing a General Practitioner (GP) as Person in Charge in each Medical Staff Committee (MSC) to coordinate the discharge process. This aims to give the GP clear responsibility for managing the discharge process, thus ensuring that the process runs smoothly and efficiently. The GP will then have the appropriate authority and power to oversee and ensure each stage of the discharge process is carried out in accordance with established standards.

The final step is to establish regulations governing the person in charge of the discharged patient's condition, including online consultations that must be conducted within 1x24 hours after the patient is discharged. This aims to ensure that there is appropriate follow-up on the patient's condition after discharge from the hospital, as well as to provide opportunities for patients and their families to obtain additional assistance or information if needed. Thus, this regulation will improve the quality of post-discharge care and reduce the risk of complications or the need to return to the hospital.

The analysis conducted shows that X General Hospital faces a number of challenges in implementing the H-1 discharge planning strategy. Some of the problems identified include a lack of uniform understanding among DPJPs regarding the H-1 discharge planning program, not all DPJPs have participated in the socialization of the program, there is no standard communication between PPAs regarding the H-1 discharge planning program to patients and their families, there is no policy regarding fee compensation for DPJPs on the day of discharge if no visit is made, lack of standardization of communication related to patient discharge, coordination between PPAs via telephone or WhatsApp is not optimal, and coordination with third parties or guarantors via telephone or email is not effective.

Therefore, to implement early discharge planning successfully, strong collaboration between various parties in the hospital is required, including DPJPs, nurses, and management. Effective socialization, clear policies, and good coordination are essential to ensure the program runs optimally. The

implementation of these measures will help reduce patient hospitalization time and improve the efficiency of health services.

CONCLUSION

The analysis of EDP implementation at X General Hospital from March to May 2024 is based on the comparison between the monthly achievement rates and the target standard of 80%. The data considers the numerator (number of patients provided with H-1 discharge plan instructions) and the denominator (total number of hospitalized patients discharged) for each inpatient unit. Some of the problems identified include lack of uniform understanding among Doctors Responsible for Patients (DPJP) regarding the H-1 discharge planning program, less than optimal participation from all DPJP in socializing the program, lack of communication standards between Administrative Service Officers (PPA) regarding the discharge planning program D-1 to patients and their families, there is no policy regarding compensation for DPJP on the day the patient is discharged if no visit is made, lack of standardization of communication regarding patient discharge, less than optimal coordination between PPA via telephone or WhatsApp, and lack of effective coordination with third parties or guarantors by phone or email.

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