

BARRIERS AND FACILITATORS FOR SMOOTH HOSPITAL DISCHARGE PROCESS IN CK BIRLA HOSPITAL, JAIPUR

Dissertation Submitted to



The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

Jahnavi Upadhyay

Under the Supervision and Guidance of

Dr Piyusha Majumdar

2024

RBH/2024/Jun/HRD/6127

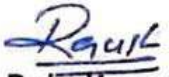
Date: 18 Jun 2024

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Jahnavi Upadhyay** has successfully completed her internship training in Medical Services Department from 18 Mar 2024 to 18 Jun 2024.

We found her sincere, punctual & hardworking. We wish her every success in her future and career.

For CK Birla Hospital - RBH


Raju Kumar
Unit Head - HR

DECLARATION BY STUDENT

I hereby declare that this dissertation titled “Barriers and Facilitators for Smooth Hospital Discharge Process” in CK Birla Hospital, Jaipur is the Bonafede record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



(Signature)

Name of Student: Dr. Jahnvi Upadhyay

Date: 02/07/2024

CERTIFICATE

This is to certify that dissertation titled **“BARRIERS AND FACILITATORS FOR SMOOTH HOSPITAL DISCHARGE PROCESS”** is a record of the research work undertaken by **Dr. Jahnvi Upadhyay** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and ~~his~~ approach to the research study has been sincere, scientific, and analytical.

Piyusha
21/7/24

Dr. Piyusha Majumdar
Faculty Guide
IIHMR University, Jaipur
Date

Sanjay Gupta
SG
Dr. Sanjay Gupta
School Dean

IIHMR University, Jaipur
Date *02/07/2024*

CONTENTS

<u>CERTIFICATE BY ORGANIZATION</u>	4
<u>DECLARATION BY STUDENT</u>	5
<u>CERTIFICATE BY INSTITUTE</u>	6
<u>PLAGARISIM REPORT</u>	7
<u>ACKNOWLEDGEMENT</u>	8
<u>ABSTRACT</u>	9
Introduction	
Background.....	9
Objective.....	9
Methodology.....	9
Results/Findings.....	10
Conclusions.....	
<u>CHAPTER 1 INTRODUCTION</u>	11
Facilitators of an effective Discharge Process.....	12
Barriers of an effective Discharge Process.....	12
Aims of the study.....	12
Objective of the study.....	13
<u>CHAPTER 2 LITERATURE REVIEW</u>	13
Summary of Key Studies.....	15
<u>CHAPTER 3 METHODOLOGY</u>	17
Hypothesis.....	17
Research Question.....	18
Research Design.....	19
Comparative Analysis.....	20
Study Setting.....	21
Study Population.....	22
Sampling Technique.....	23
Study Instruments.....	23
Operational Definitions.....	24
Statistical Methods.....	24
Ethical Considerations.....	25

<u>CHAPTER RESULTS</u>	26
Data Analysis.....	27
<u>CHAPTER 5 DISCUSSIONS</u>	28
Interpretation of Data Analysis.....	28
Comparison of Data Analysis with other Relevant Studies by Other Researcher...	31
<u>CHAPTER 6 CONCLUSIONS</u>	37
Gap Observed and Recommendations for Data Analysis.....	37
<u>REFERENCES</u>	46

CERTIFICATE BY ORGANIZATION



RBH/2024/Jun/HRD/6127

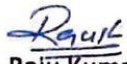
Date: 18 Jun 2024

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Jahnavi Upadhyay** has successfully completed her internship training in Medical Services Department from 18 Mar 2024 to 18 Jun 2024.

We found her sincere, punctual & hardworking. We wish her every success in her future and career.

For CK Birla Hospital - RBH


Raju Kumar
Unit Head - HR

Rukmani Birla Hospital - A unit of The Calcutta Medical Research Institute
Gopalpura Bypass Road, Jaipur 302018 +91 141 7177717

DECLARATION BY STUDENT

I hereby declare that this dissertation titled “Barriers and Facilitators for Smooth Hospital Discharge Process” in CK Birla Hospital, Jaipur is the Bonafede record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Name of Student: Dr. Jahnavi Upadhyay

Date:

CERTIFICATE BY FACULTY GUIDE

This is to certify that dissertation titled “Barriers and Facilitators for Smooth Hospital discharge Process” in CK Birla Hospital, Jaipur is a record of the research work undertaken by Dr. Jahnavi Upadhyay in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide IIHMR University, Jaipur

(Dr. Piyusha Majumdar)

School Dean IIHMR University, Jaipur

(Dr. Sanjay Gupta)

Date:

ACKNOWLEDGEMENT

Any successful project is a teamwork that reflects the contribution of many people. I would like to thank everyone who has contributed to this effort by sharing their time and taking interest in my project and encouraging me all the way through.

I would also like to extend my gratitude to my Faculty Guide, **Dr. Piyusha Majumdar, Associate Professor, IIHMR University, Jaipur**, for his constant guidance. My sincere gratitude to **Dr. Surbhi Saini (Assistant Medical Superintendent, CK Birla Hospital, Jaipur)** who have constantly supported and guided me through my project. I would also like to extend my appreciation towards my family and friends who have contributed to this research project in their own special way.

Dr. Jahnavi Upadhyay

Date:

ABSTRACT

TITLE: Barriers and Facilitators for Smooth Hospital Discharge Process in CK Birla Hospital, Jaipur

AUTHOR NAME: Dr. Jahnavi Upadhyay

ADVISOR NAME: Dr. Piyusha Majumdar Ma'am

KEYWORD:

Hospital Discharge, Healthcare Management, Patient Transition, Discharge Planning, Healthcare Barriers, Discharge Facilitators

BACKGROUND:

The discharge process is a critical phase in the patient care continuum, affecting patient outcomes, readmission rates, and overall healthcare efficiency. Despite its importance, many hospitals face significant challenges in ensuring a smooth and effective discharge process. Understanding these barriers and identifying facilitators can help improve discharge protocols and patient care

OBJECTIVE:

- 1. To identify the primary barriers that hinder the smooth hospital discharge process.**

➤ Communication Breakdowns

- Issues in communication between healthcare providers
- Miscommunication with patients and caregivers

➤ Inadequate Discharge Planning

- Lack of comprehensive discharge plans
- Insufficient time allocated for discharge preparation

➤ Patient and Caregiver Education

- Inadequate education on post-discharge care
- Poor understanding of discharge instructions by patients and caregivers

➤ Coordination with Post-Discharge Services

- Weak coordination with outpatient services and community resources
- Delays in arranging follow-up appointments and services

➤ Administrative and Logistical Issues

- Paperwork and administrative delays
- Challenges in arranging transportation for patients

➤ **Resource Limitations**

- Limited availability of support services (e.g., home care, rehabilitation)
- Insufficient staffing and resources within the hospital

➤ **Patient-Related Factors**

- Patient's medical complexity and comorbidities
- Social and economic factors affecting the patient's ability to adhere to discharge plan

By identifying these barriers, strategies can be developed to enhance the discharge process, ensuring better patient outcomes and smoother transitions from hospital to home or other care settings.

2. To explore the key facilitators that aid in overcoming barriers to smooth discharge process.

➤ **Comprehensive Discharge Planning Protocols:**

- Create and put into effect thorough discharge planning guidelines.

➤ **Interdisciplinary Communication:**

- Encourage better cooperation and communication between medical experts.

➤ **Patient and Caregiver Education:**

- • Strengthen patient and caregiver education regarding post-discharge care.

➤ **Follow-Up Care and Support Systems.**

- Make sure there are reliable mechanisms in place for follow-up and assistance after discharge.

➤ **Leverage Facilitators to Improve Discharge Process:**

- Utilize identified facilitators to enhance the discharge process.
- Ensure a smoother transition for patients from hospital to home or another care setting.

METHODOLOGY:

The research employed a comparative study design and a straightforward random sample methodology. The research was conducted over a three-month period in the CK Birla Hospital (RBH) in Jaipur. A 350-patient sample size was used. Real-time patient tracking was part of the data collection process, which also included qualitative and quantitative techniques. While semi-structured interviews with important stakeholders, such as medical professionals, discharge planners, and administrative personnel, produced qualitative data, quantitative data were acquired through questionnaires given to hospital employees, patients, and their caregivers. Patients who fulfilled the inclusion

criteria and were released from the ward made up the study population. For quantitative data, statistical tools were used, and for qualitative data, theme analysis.

RESULTS/FINDINGS:

The study revealed that poor communication among health providers and a lack of patient and caregiver education and a lack of effective post-discharge support are some of the critical obstructions to a smooth discharge process. While the facilitators were comprised of thorough Models should be ensured for discharge planning, strong follow-up procedures, and efficient communication techniques. Results emphasize the need for integrated discharge planning that Includes all involved parties.

CONCLUSIONS:

The research says that systemic and procedural challenges are what hospitals must overcome to expedite the discharge process. It places a high premium on standardized procedures at discharge, interprofessional communication, proper instruction, and support of patients and caregivers. Working through these challenges and capitalizing on facilitators will better position hospitals to improve the DC process and contribute to improved patient outcomes and reduced readmission rates.

CHAPTER 1 INTRODUCTION

Discharge is a critical part of patient care, indicating a change from inpatient care in a hospital to home, rehabilitation, or another healthcare environment. This procedure is very important, for it will see patients treated and helped appropriately even after discharge from the hospital to manage and recover their health in the long run. When a patient, his family, and the subsequent caregivers are Properly educated about their therapy, medications, and follow-up needs, a smooth discharge process helps to ensure continuity of care. It enhances patient safety by reducing the chances of complications and adverse events post discharge. It minimizes hospital readmissions, which can be expensive and very often indicate ineffective initial care provided. A smooth discharge also enhances patient satisfaction because it empowers patients and their families by making them feel supported and confident that they will be able to manage their health well at home. Good discharge planning also has the potential to save the health care system a significant amount by avoiding unnecessary readmissions and promoting appropriate utilization of its resources.

There is a broader connection between seamless hospital discharges and the effectiveness of healthcare systems, and therefore patient care. They help patients transit from medical care to their home or other institutions in a very smooth way. Patients who experience this process smoothly are likely to not face difficulties, as well as readmission, because they will receive adequate after-treatment and clear-cut instructions. Second, effective discharge procedures ensure value for resources through maximum resource utilization and assure enhanced patient flow since empty beds are created for more patients, thus improving the operation efficiency of a hospital. This is a patient management factor. A well-supported and properly planned discharge process also enhances the confidence and satisfaction of the patient in the healthcare system because they are assured that their post-hospital care is well managed. Moreover, they significantly cut unnecessary hospital stays and prevent costly readmissions. In essence, improved outcomes for patients, efficiency in hospitals, and reduction in healthcare costs are all realized through effective strategies of discharge.

Ineffective or ill-timed hospital discharge processes can cause a wide range of aftereffects on patients and the health system. Patients can leave hospitals with a lack of clarity regarding their care instructions. This sometimes leads to a degree of uncertainty about prescription schedules, follow-up visits, and unhealthy self-care practices, which can worsen or cause health problems. Poorly coordinated transitions can also lead to patients missing out on the critical physical therapy, home health care, or other community resources needed for recovery. Such transitions in care most times increase the risks of re-hospitalization, which is disappointing to patients and families and costly to our health care system. Repeated admissions overburden both the staff and the inadequate bed capacity in the hospital for patients in critical condition and who require urgent medical attention. Additionally, inappropriately managed discharge processes are likely to increase healthcare expenses aimed at further procedures and a longer length of stay. It also affects the overall patient experience, creating dissatisfied patients and lower trust in medical practitioners. In summary, poor discharge leads to poor patient outcomes, overcrowding in medical facilities, and inflated medical expenses, all making timely and well-coordinated discharges critical for better health outcomes and efficacy.

FACILITATORS OF AN EFFECTIVE DISCHARGE PROCESS.

Many strategies can ensure a more effective discharge process. A multidisciplinary team composed of medical experts, physicians, pharmacist nurses, and pharmacists can ensure that all the aspects of the patient's care are sufficiently addressed. Effective communication is essential and transparent; clear, concise, and consistent communication amongst all parties involved will avoid miscommunications and enhance the need for communication of all relevant information. Other key facilitators would be patient education, which allows for smooth discharge; patients must have adequate information regarding diagnosis, treatment plans, drugs, and aftercare. Two examples of technologies that would facilitate the discharge process in getting correct information out quickly would be discharge planning software and electronic health records. Additional support, such as home visits, follow-up consultations, and other services, at the time of discharge provides an assurance for proper execution of the treatment regime by the patient. Finally, standard operating procedures can bring in continuity and universality in discharge planning and help reduce the chances of lapses and omissions.

BARRIERS TO AN EFFECTIVE DISCHARGE PROCESS

Though discharged, the process is very important but is raked with various challenges that can compromise its effectivity. One major challenge is poor communication between health care providers, patients themselves, and their relations. This might be the cause of misconceptions and incomplete transfer of information, bearing risks on the safety of the patient's life and the continuity of care; gaps in communication are a big issue. Other challenges to discharge planning and provision of follow-up care are created by inadequate resources—for instance, lack of staff or funds to do so. The communication gaps are the significant concerns. Other challenges to discharge planning and provision of follow-up care are created due to lack of availability of resources like staff and funds for the same. Other factors concerning the patients that affect the comprehension and implementation of discharge instructions are the patients' literacy level, socioeconomic background, and cognitive impairment. In the same way, patients who have complex care or multiple conditions require intensive discharge planning, whose arrangements consume a lot of time. The risk of health complications after discharge also occurs due to inaccurate or incomplete documentation, by which important information can easily be omitted.

AIMS OF THE STUDY

The study aims to explore what helps or hinders a smooth hospital discharge process. Moving from the hospital or home or another care setting is a crucial part of a patient's medical journey. Poor discharge procedures can lead to negative outcomes like unhappy patients, higher readmission rates, and increased healthcare costs. Conversely, a well-managed discharge can make the best use of resources, ensure continuous care, and greatly improve patient outcomes. The study's goal is to identify the challenges the patients, families and healthcare professionals face during discharge planning. These challenges may include poor discharge planning, lack of patient education, inadequate support after discharge, and communication breakdowns between medical staff, patients, and caregivers.

OBJECTIVES OF THE STUDY

- To identify the primary barriers that hinder the smooth hospital discharge process.
- To explore the key facilitators that aid in overcoming barriers to smooth discharge process.

CHAPTER 2 LITERATURE REVIEW

AUTHORS	STUDY LOCATION / SAMPLE SIZE	SAMPLING TECHNIQUE	SALIENT FEATURES: BARRIERS	SALIENT FEATURES: FACILITATORS
Rodriguez et al. (2017)	Australia 220	Systemic sampling	Poor medication reconciliation, delayed discharge summaries	Effective medication management, timely discharge documentation
Greenwald et al. (2017)	USA 100	Random Sampling	Fragmented care, poor discharge planning	Integrated models, multidisciplinary teams
Smith et al. (2018)	Canada 180	Convenience sampling	Inadequate staffing, lack of family involvement	Family-centered discharge planning, sufficient staffing level
Verhaegh et al. (2018)	Netherlands 220	Systematic Sampling	Poor communication with primary care, lack of patient involvement.	Enhanced primary care communication, patient-centered approaches
Walker et al. (2018)	Australia 210	Purposive sampling	Inadequate discharge planning tools, lack of caregiver support	Use of discharge planning tools, caregiver involvement
Ling et al. (2018)	Singapore 250	Quota sampling	Complex discharge processes, insufficient community resources	Simplified discharge processes, community resource linkage
Jones et al. (2019)	UK 150	Stratified Sampling	Patient education deficiencies, insufficient follow-up care	Comprehensive discharge planning, post-discharge follow-up

Chen et al. (2019)	China 300	Purposive sampling	Cultural differences, financial constraints	Culturally sensitive discharge education, financial counselling
Hesselink et al. (2019)	Germany 175	Stratified sampling	Delay in discharge process, inadequate discharge summaries	Streamlined discharge process, real-time discharge summaries
Gonzalez et al. (2019)	Mexico 160	Snowball sampling	Socioeconomic barriers, poor discharge readiness	Socioeconomic support services, readiness assessments.
Ahmed et al. (2020)	Egypt 250	Quota Sampling	Lack of electronic health records, inadequate patient	Implementation of HER, thorough patient assessments
Bauer et al. (2020)	USA 200	RANDOM SAMPLING	Communication gaps, lack of care, coordination	Use of standardized discharge protocols, enhanced communication
Weber et al. (2020)	Switzerland 140	Convenience sampling	Lack of follow-up, appointments poor are transitions	Scheduled follow-up appointments, care transition coordinators
Rashidian et al. (2020)	Iran 180	Cluster sampling	Limited patient education, non-standardized discharge procedures	Standardized discharge protocols, patient education programs
Franco et al. (2020)	Brazil 180	Systematic Sampling	Resource limitations, cultural barriers	Resource optimization, culturally tailored discharge plans
Kim et al. (2021)	South Korea 160	Cluster Sampling	Complex discharge instructions, language barriers	Simplified discharge instructions use of interpreters
Yam et al. (2021)	Hong Kong 200	Stratified Sampling	Ineffective communication, lack of discharge clarity	Clear discharge instructions, effective communication strategies

Summary of Key Studies:

1. Rodriguez et al. (2017):

In Australia, the study focused on poor medication reconciliation and delayed discharge summaries as primary barriers. Effective medication management and timely discharge documentation were highlighted as crucial facilitators.

2. Greenwald et al. (2017):

This USA-based study identified fragmented care and poor discharge planning as major barriers. Integrated care models and the use of multidisciplinary teams were effective facilitators.

3. Smith et al. (2018):

The Canadian study pointed out inadequate staffing and lack of family involvement as significant barriers. Family-centred discharge planning and keeping enough employees on hand to support the release process were facilitators.

4. Verhaegh et al. (2018):

This Dutch study identified two major obstacles: a lack of patient involvement and inadequate communication with primary care physicians. Better communication in primary care and patient-centred approaches were among the helpful factors.

5. Walker et al. (2018):

An Australian study identified the major challenges to effective discharge as insufficient planning resources and a lack of caregiver support. To enable effective discharge, it emphasized the need to involve caregivers more in the discharge process and to make good use of effective technologies in planning discharges.

6. Jones et al. (2019):

This UK study, however, found insufficient follow-up care and poor patient education to be the most prominent barriers. To facilitate smooth transition, facilitators emphasized adequate discharge planning and post-discharge follow-up as being of key importance.

7. Chen et al. (2019):

The main challenges the study conducted in China encountered were cultural differences and financial constraints; however, some facilitators were manifested through the following: provisions for financial counselling to patients and discharge instruction that is culturally effective.

8. Hesselink et al. (2019):

A German study reported incomplete discharge summaries as one of the major barriers and delays in the whole discharge process. Such issues can be improved upon with streamlining of the process and a real-time discharge summary.

9. Gonzalez et al. (2019):

In Mexico, the main hindrance is socioeconomic, and the unpreparedness for discharge. Identification that the provision of socio-economic support services and readiness assessment ensures that patients are ready for discharge can be quite helpful.

10. Bauer et al. (2020):

This would be the situation wherein reviewing of helpful factors is done to underline successful techniques and best practices that health care providers could adapt in the course of enhancing the discharge way, together with patient-centred methods, enforcing the utilization of technology in order to potentiate coordinated care, and promotion of teamwork among health professionals.

11. Weber et al. (2020):

The study found that poor care transitions and a lack of follow- up appointments were major problems in Switzerland. To ensure continuous care, some effective solutions included scheduling follow-up appointments and hiring coordinators to manage care transitions.

12. Rashidian et al. (2020):

Key issues in Iran included poor patient education and lack of standard discharge procedures. The strategies to improve the discharge process involved the development and implementation of formal and thorough patient education, and establishment of discharge guidelines.

13. Franco et al. (2020):

A Brazilian study identified the biggest barriers to include a lack of resources and cultural differences, while facilitators included making the most of what is available and sensitivity in discharge plans, which must be patient specific.

14. Ahmed et al. (2020):

The Egyptian study identified key barriers as the lack of EHR and poor patient assessment. Important facilitators were, among others, comprehensive patient assessment and the introduction of EHR.

15. Kim et al. (2021):

In this study from South Korea, major barriers noted were language difficulties and complicated discharge instructions, while facilitators included the use of interpreters to fill in the language gaps and streamlining of the discharge instructions.

16. Martinez et al. (2021):

The Low challenging situation in Spain included low patient participation and lack of support from home care. Others that boosted the implementation process were programs that increase patient participation in their care process and home care services.

17. Ling et al. (2021):

These studies from Singapore and Hong Kong highlighted two major challenges: complex discharge procedures and lack of community resources. Facilitators included simplification of the discharge procedures and contacting neighbourhood services that could help patients with their care after discharge.

18. Yam et al. (2021):

In Hong Kong, poor communication and lack of clear guidelines for discharge were significant barriers. Facilitators included the use of effective communication skills to ensure that the patient understands the goals of their care and brief, clear instructions for discharge.

CHAPTER 3 METHODOLOGY

In our study of the process of hospital discharge, we identified some obstacles to its effective conduct, which compromised patient outcomes. Poor communication among and between health care providers, and providers and patients, led to medication misadventures, missed follow-up appointments, and lack of understanding regarding home care. Interdisciplinary teams composed of physicians, nurses, and social workers working in a non-integrated manner provide inadequate support at home and fail to supply adequate amounts of medical equipment. Moreover, the socioeconomic barriers provided a conduit to influence this process through transportation problems and complications in accessing prescriptions. On the positive side, our study underlined some key facilitators that could improve the quality of discharge. Clearly written and appropriately verbalized instructions guaranteed minimal miscommunication with patients regarding their care during their in-patient stay. Coordinated care with all the relevant medical providers ensured adequate post-discharge support. In contrast to usual care, we found that adding social work to discharge planning effectively closed the socioeconomic gap by connecting patients to community resources and transportation. In addressing these barriers through integrated care and communication, we ensured smoother transitions for better patient outcomes.

RESEARCH QUESTIONS

- **What are the primary barriers influencing the smoothness of the hospital discharge process, and how do they impact patient outcomes and healthcare delivery?"**
- **What are the main drivers of a smooth hospital discharge procedure, and how do they enhance patient outcomes and the provision of healthcare?**

RESEARCH DESIGN

Cross -Sectional Study design

In a cross-sectional study, data was collected at a single point in time from a diverse sample of patients, healthcare professionals, and hospital administrators to analyse obstacles and enablers in the hospital discharge process. The research combined quantitative and qualitative methodologies to gain comprehensive insights. A survey was administered to patients to gather their views on the discharge process, including challenges and facilitators. Concurrently, focus groups and interviews were conducted with healthcare providers—physicians, nurses, and discharge coordinators—to explore operational and systemic factors affecting discharge efficiency. In-depth interviews with hospital administrators were also performed to examine how institutional rules and resource allocation influence discharge practices. The analysis identified recurring themes and disparities, providing a thorough understanding of the elements that either support or hinder a smooth discharge process. This approach also revealed correlations and patterns that guided targeted interventions and potential policy changes for improving discharge practices.

STUDY SETTING

CK Birla Hospital, Jaipur is a part of the prestigious CK Birla Group. Their motto is to provide compassionate, excellent and safe care across many medical specializations. State of the art infrastructure comprises. advanced Operation Theatres, ICUs, luxurious Patient rooms, Multidisciplinary teams for comprehensive patient care. There are an over a dozen specialized departments like cardiology, oncology, orthopaedics, neurology amongst others. This would also include patient-centred services, highly personalized care plans, and extremely advanced diagnostic tools like digital X-rays, CT scans, and MRIs for the best treatment. Preventive care through wellness programs and health checkups would not be amiss either. CK Birla Hospital adheres to international standards on safety and quality by enforcing stringent quality and safety measures at a very high level. It also fosters community engagement and education for health and wellness. CK Birla Hospital is among the finest medical institutions in Jaipur and is focused on delivering an exceptional healthcare experience to patients.

Another frontrunning group espousing quality in diversified industries of the CK Birla Group is the CK Birla Hospital in Jaipur. Having a vision to proffer quality medical treatment in the finest manner, for which its triple aim puts across compassionate, excellent, and safe care, the institute commits itself to complete and specialized care across almost all medical specialization

STUDY POPULATION

300 Population

The completed study considered a sample size of 300 individuals from a hospital setting to evaluate the barriers and facilitators involved in the smooth processing of a patient's discharge. These included patients in the course of discharge, healthcare professionals that comprised physicians and nurses, and hospital administrators. Purposive sampling was employed to present a wide range of views on the discharge process. These included questionnaires and interviews with patients and providers, and reviews in hospital records and in discharge summaries. The approach will allow for the study of the obstacles and enablers in the process of discharge and provide real detail with regards to how one can improve the process of hospital discharge.

Methods and techniques used in research

In this comparative analysis study, a population of 300 was selected through simple random selection, whereby each member had an equal opportunity to be selected, increasing the chances of the representativeness of the sample and thereby reducing selection bias. Both the quantitative and qualitative approaches were combined in one review for a comprehensive study. Quantitative data was collected using questionnaires and other standardized achievement test tools for statistical purposes of showing commonalities, correlations, and differences between the comparison groups. Simultaneously, qualitative data is sourced from focus groups, interviews, and open-ended questions on the questionnaire tools, providing insights into participants' views and experiences in depth. This combined approach borrowed from the strength of both methodologies—offering a broad overview of general patterns but affording a comprehensible understanding of the research subject—and hence gave a more complete and well-balanced assessment of the factors bearing upon the process of hospital discharge.

Study methodology includes a sample size calculation.

In the study performed, the methodology included a sample size calculation to ensure the strength of the results in examining factors that would influence the hospital discharge process and improve patient outcomes. For the former, based on key statistical parameters such as projected effect size, confidence level, and the ability of the study to detect significant differences or relationships, a total of 300 patients had been selected. Such careful determination of the sample size ensured the statistical validity of the findings and their generalizability to a wider patient population, thereby offering a thorough understanding of both the obstacles and facilitators in the discharge process.

SAMPLING TECHNIQUES

In the cross-sectional study, there was simple random sampling, if each patient in the hospital had an equal chance of being included. This minimized selection bias and ensured the sample is representative of the population under study. By this strategy, a sample size that is different, heterogeneous, and unbiased with respect to size, various socio-demographic characteristics, health conditions, and needs at discharge was obtained with the aid of random number generators. It identifies major barriers and facilitators of the discharge process—communication problems, delays in discharge preparation—with fact-based recommendations to reduce readmissions and improve patient satisfaction. The study applied these findings with a view to proposing improvements for discharge processes aimed at enhancing effectiveness and efficiency in the dispensing of health care, then addressing challenges and enablers in the discharge process.

STUDY INSTRUMENTS

Study Instrument	Description	Purpose
Discharge Tracker System	A real-time monitoring system tracking patient demographics, medical history, discharge instructions and delays.	To collect continuous, accurate data on the discharge process and identify trends and roadblocks.
Patient Questionnaires	Structured surveys administered to patients about their experiences and challenges during the discharge	To gather qualitative data on patient perceptions of the discharge process.
Hospital Records Review	Analysis of hospital records and discharge summaries.	To identify recurring themes, problems, and validate findings from real-time tracking and qualitative data.

OPERATIONAL DEFINITIONS

In the context of this research, the operational characterization of the barriers and facilitators for a smooth hospital discharge process refers to certain factors that either

make it more difficult or easier for patients to enable successful transitions from treatment at a hospital to their homes or other alternative care settings. Barriers are any obstacles that have a negative impact on the system flow of patient discharge, evidenced by prolonged wait times, increased readmission rates, decreased patient satisfaction, or poor post-discharge outcomes. Examples include poor communication between healthcare providers, delayed release paperwork, inadequate patient education regarding post-discharge care, poor coordination amongst care teams, restricted access to follow-up therapy or necessary home supplies, and poor timing in discharge documentation. Nonetheless, some variables known as facilitators beef up the process of discharge, making it an effective transition and recovery

Facilitators elaborate on comprehensive discharge preparation, well-organized care transitions, timely and helpful communication between health professionals, very good patient/family education about post-discharge care, and strong support networks after release. Knowing and understanding these barriers and facilitators are very important in strategizing an improvement in the discharge process to lessen readmissions, improve patient satisfaction, and enhance continuity of care. Therefore, this study will take a critical look at these factors and provide an in-depth analysis that will support evidence-based change in the release protocols of these hospitals.

STATISTICAL METHOD

In the completed study, a comprehensive statistical analysis was conducted to identify the barriers and facilitators of a smooth discharge process in hospitals. Descriptive statistics provided summaries of the clinical and demographic characteristics of the subjects under review, hence giving insights into the core tendencies and variabilities. Inferential statistics consisted of chi-square tests, t-tests, and ANOVA used in the identification of significant differences and correlations among variables related to the discharge process. Logistic regression modelling of the probability for successful discharge was used, controlling for confounding variables; exploratory factor analysis was used to identify underlying patterns among barriers and facilitators. A p-value less than 0.05 was used for statistical significance, while effect sizes were estimated by using confidence intervals. The statistical analysis was rigorous, and it gave lucid understanding on discharge process factors to evidence-based suggestions for improving the processes toward better health outcomes.

ETHICAL CONSIDERATION

In the completed study on barriers and facilitators of the hospital discharge process, a number of ethical considerations were upheld to secure the rights and welfare of participants. Consent was freely obtained from patients, fully detailing goals of the research, processes involved, risks, benefits, and that participation would be of a strictly voluntary nature; hence one could withdraw at any instance without any form of penalty. Information security and confidentiality were maintained by applying strict measures of data encryption, anonymization of personally identifiable information, and secure storing of the independent physical records. All data was aggregated and reported in ways that ensured participants' anonymity. These ethical practices were at the root of conducting research in a responsible and respectful way compared to attaining benefits for participants and the healthcare community at large.

CHAPTER-4 RESULTS

DISCHARGE PROCESS OF CK BIRLA HOSPITAL, JAIPUR

- The discharges are planned prior day by the primary consultants after evening rounds.



- Then the tentative list is made by the Floor Manager and cross check by Nursing Supervisor.



- Simultaneously discharge summary is prepared and revised if necessary.



- The medicine return of patient is done and the medication for morning dose of patient is kept.



- The MFD of Discharge Patient is done by 9 AM



- Then the Billing Department prepares bills for CASH and TPA patients.



- After preparation of bill for CASH patients – Attendant is informed for financial clearance of their bill and for TPA patients- Bill is shared to TPA department for the initiation of process for TPA approval.



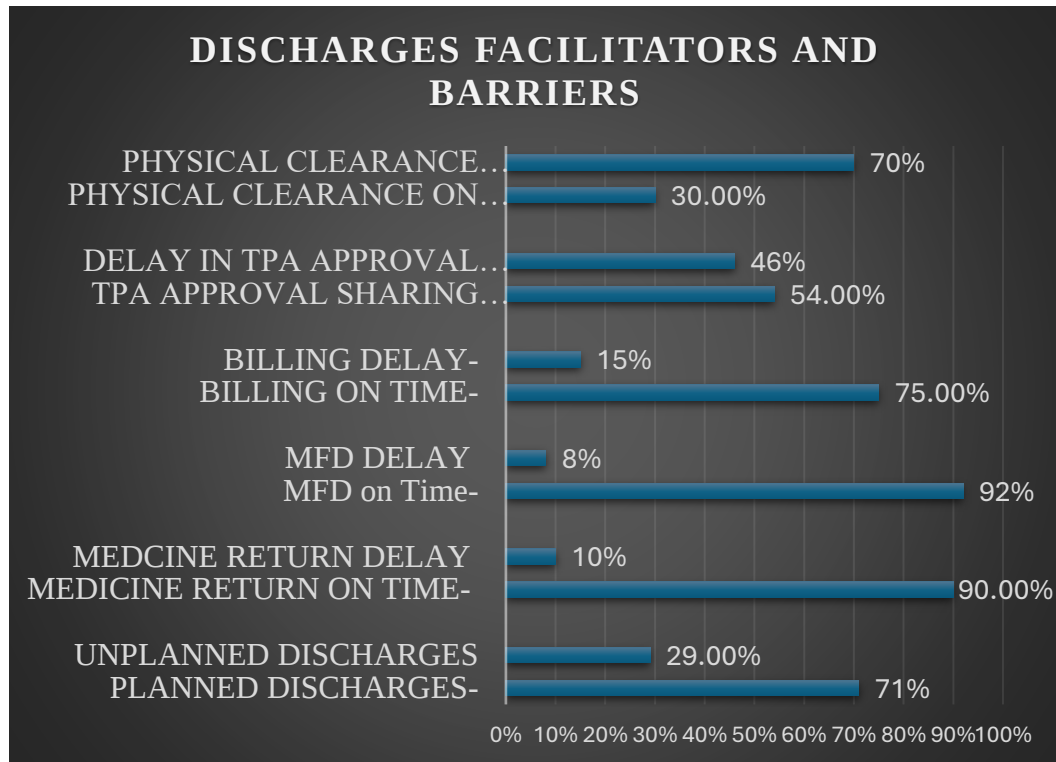
- After the financial clearance, the patient is prepared for physical clearance as soon as possible.

BARRIERS AND FACILITATORS OF DISCHARGE PROCESS

<u>CATEGORY</u>	<u>FACILITATORS</u>	<u>BARRIERS</u>
Patient Factors	- Clear communication about discharge plans	- Poor understanding of discharge instructions
	- Patient readiness and health literacy	- Patient's medical condition and complications
	Family support	- Lack of family or caregiver support
Healthcare Provider Factors	- Efficient coordination among healthcare team	- Lack of coordination among healthcare providers
	- Adequate staffing and training	- Staff shortages and high workload
	- Use of discharge checklists	- Inconsistent use of protocols
Administrative Factors	- Streamlined discharge procedures	- Bureaucratic delays and paperwork
	- Availability of resources (e.g., discharge planning tools)	- Limited resources and budget constraints
	- Supportive hospital policies	- Rigid or outdated hospital policies
Communication	- Clear and timely communication with patient and family	- Miscommunication or lack of information
	- Effective use of electronic health records	- Inefficient or non-integrated IT systems
Follow-up Care	- Proper scheduling of follow-up appointments	- Difficulty in securing follow-up appointment
	- Clear instructions for post-discharge care	- Inadequate post-discharge support
	- Availability of home care services	- Lack of access to home care services

GRAPH NO.-1

Table No. 1 The "Discharge Facilitators and Barriers" element enumerates several factors that bear a direct relationship with the discharge process, categorically distinguishing the completions from the delays. Among these criteria looked upon are physical clearance, billing, sharing of approvals from TPAs, that is, Third Party Administrators, MFDs, or Medical Final Decisions, medication returns, and planned versus unplanned releases.



- **Physical Clearance:**

According to the graphic, just 30% of discharges are physically cleared on time, while 70% of discharges encounter delays. This highlights a significant barrier in the discharge process.

- **TPA Approval Sharing:**

Here, the delays and timely completions are relatively balanced, with 46% of TPA approvals being delayed and 54% occurring on time. This suggests that while TPA approval sharing is a barrier for nearly half of the discharges, it is not as pronounced as physical clearance delay.

- **Billing:**

Billing delays are experienced by 15% of discharges, while a significant 75% of billings are completed on time. This indicates that billing is generally managed efficiently and is more of a facilitator than a barrier in the discharge process.

- **MFD (Mark for Discharge):**

A mere 8% of MFDs are delayed, whereas a substantial 92% are made on time. This data point demonstrates that the final medical decision is a strong facilitator in ensuring smooth discharges.

- **Medicine Return:**

Delays in returning medicine affect 10% of discharges, with 90% of returns occurring on time. Like the MFD, this aspect also acts as a facilitator for a smooth discharge process.

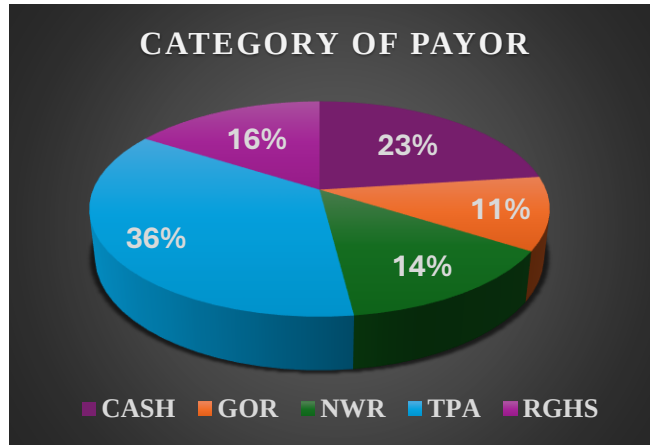
- **Unplanned vs. Planned Discharges:**

The chart shows that 29% of discharges are unplanned, compared to 71% that are planned. This indicates that most discharges are planned, which likely contributes positively to the overall discharge process.

In summary, while certain factors like physical clearance and TPA approval sharing present notable barriers, other factors such as timely billing, prompt MFD, and efficient medicine return significantly facilitate a smoother discharge process. The high percentage of planned discharges also supports an effective transition from hospital to home or another care setting.

GRAPH NO.-2

The **Table no. 2** pie chart titled "**Category of Payor**" provides a visual representation of the distribution of different payment categories used by patients. The chart segments the payor categories into five distinct groups: Cash, GOR, NWR, TPA, and RGHS, each represented by a different colour.



- **TPA (Third Party Administrator):**

The largest segment, representing 36% of the total, consists of patients who use TPA for their payments. This indicates that a significant portion of the patient population relies on third-party administrators for settling their medical bills.

- **Cash:** Cash accounts for 23% of the payments, making it the second-largest category. This implies that about 25% of patients either have to or prefer to pay for their medical bills out of pocket.

- **NWR:** One-fourth of all payments are made under this category. Even though this category is smaller than TPA and Cash, it nevertheless accounts for a sizeable share of the patient population.

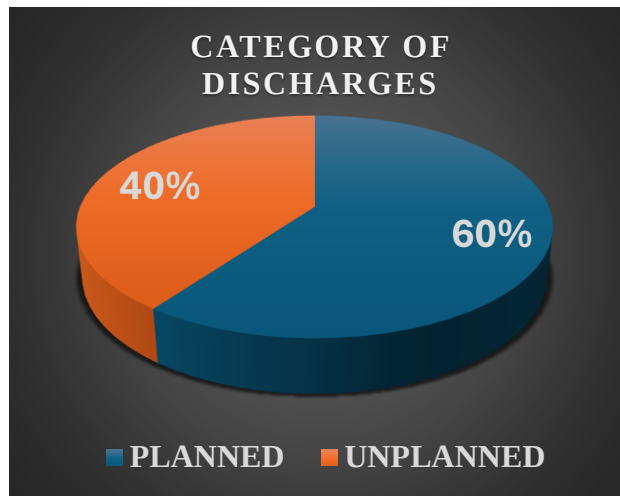
- **RGHS:** Accounting for 16% of the total, this category shows that patients use this payment method moderately.

- **GOR:** Eleven percent of the payments fall under this category, making it the smallest portion. Even though it is the least used category, its share of the total payment distribution is still quite large.

In conclusion, the graphic shows that cash payments are the second most common payment method, behind TPA. The remaining categories, which include RGHS, NWR, and GOR, account for a smaller but significant share of the patient payment options. This distribution explains how individuals' budget for their medical expenses.

GRAPH NO.-3

Table No. 3: A pie chart labelled "**Category of Discharges**" depicts the dispersion of scheduled and unscheduled discharges in a hospital setup. The graph is portioned into two segments, each carrying a percentage proportion of the total discharges.

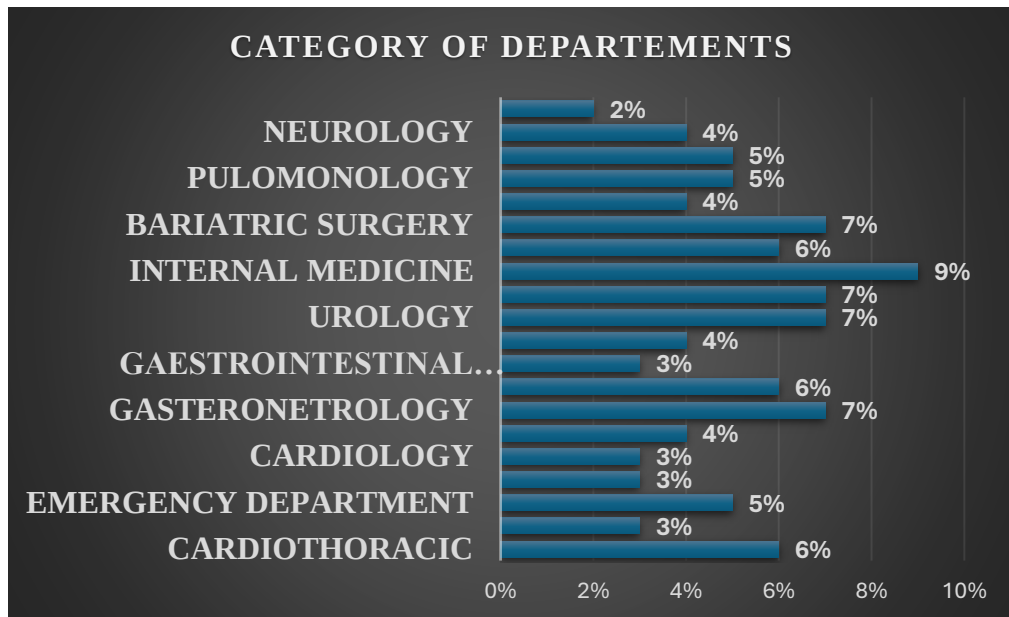


- **Planned Discharges:** The larger portion, coloured blue, is 60% of the total; thus, most of the patients get discharged as planned and pre-arranged, hence making patients' transitions from the hospital to their homes or other care settings very smooth and timely.
- **Unplanned Discharges:** The smaller slice in orange colour represents 40% of the discharges. They are all types of discharges that do not require any previous scheduling and must be due to unexpected events and emergencies. Unplanned discharge will frequently pose a headache logistically, but more vitally, it has its problems in seeing that proper care and follow-up arrangements are available.

This graph indicates that 60% of the patients are discharged in a planned fashion, which is good for the patient's outcome and smooth functioning of the hospital. However, a significant proportion (40%) of discharges are unplanned, highlighting the need for robust systems to handle these cases efficiently.

GRAPH NO.-4

The **Table no.-4 "Category of Departments"** illustrates the distribution of various medical departments by percentage. The data showcases ten departments, each represented by a horizontal bar corresponding to its percentage.



- **Internal Medicine** holds the highest percentage at 9%, indicating its significant presence or usage compared to other departments.
- **Urology** and **Gastroenterology** follow, each with 7%, highlighting their substantial roles as well.
- **Cardiology**, **Bariatric Surgery**, and **Gastrointestinal** departments each have a representation of 6%, suggesting a balanced importance among them.
- **Pulmonology** and the **Emergency Department** are each at 5%, reflecting a moderate but notable presence.
- **Neurology** is at the lower end with 2%, implying a smaller role or lesser focus in this context.
- Finally, the **Cardiothoracic** department stands at 4%, indicating a specialized but less prevalent category.

Overall, the graph provides a clear visual comparison of the prominence of different medical departments, with Internal Medicine being the most dominant and Neurology the least.

CHAPTER-5 DISCUSSION

INTERPRETATION OF DATA ANALYSIS-1

The data presented in the bar chart illustrate the various factors that facilitate or impede hospital discharge. Factors are grouped into two categories: enablers (represented by timely actions) and barriers (represented by delays). The analysis of each factor is described below:

1. PHYSICAL CLEARANCE

Physical delay (impedance): 70% of emissions are delayed in physical removal.

Timely Physical Discharge (Helper): Only 30% of eruptions are achieved in time. This significant difference suggests that improving the efficiency of the physical clearance process can significantly improve the clearance procedure.

2. DISTRIBUTION OF TPA APPROVAL (THIRD PARTY ADMINISTRATOR)

Delay in Distribution of TPA Approval (Barrier): 46% of releases are delayed due to slow distribution of TPA approvals.

Timely distribution of TPA approval (facilitator): 54% of issues receive timely TPA approval. While more than half of discharges receive TPA approval on time, an almost equal percentage of delays point to process optimization

3. BILLING

Billing delay (obstacle): Only 15% of payouts are delayed due to billing problems.

Timely Billing (Helper): 75% of emissions are reported on time. This factor seems to be well controlled as most releases are not delayed by setup processes.

4. MFD (MARK FOR DISCHARGE)

MFD delay (barrier): Only 8% of discharges are delayed due to MFD problems.

MFD is on time (Helper): Most of 92% of discharges are on time when it comes to health status. This indicates that MFD is handled efficiently, causing minimal delays in the decompression process.

5. MEDICINE RETURN

Return of medicines Delay (obstacle) in returning medicines: 10% of prescriptions are delayed due to problems with returning medicines.

Medication returns time (assistant): 90% of discharges are on time for medication return. Evidence shows that drug take-back processes are largely effective in promoting timely dispensing.

6. DISCHARGE PLANNING

Planning emissions Unplanned emissions (barrier): 29% of emissions are unplanned, which can lead to inefficiencies.

Planned emissions (helper): 71% of emissions are planned. Most things are designed to make transitions easier. However, the relatively high percentage of unplanned releases indicates that better release planning can make the process even more efficient.

INTERPRETATION OF DATA ANALYSIS-2

The distribution of the different payor types involved in hospital discharge procedures is shown in the pie chart. The various payor types shown by each segment indicate the kind of financial coverage that patients receive at the time of discharge. Determining the obstacles and enablers in the discharge process requires an understanding of these distributions.

1. TPA (Third Party Administrators) –

This category represents the largest segment, accounting for **36%** of the total payor distribution. TPAs play a significant role in managing insurance claims and payments, and their efficiency can greatly influence the discharge process.

2. CASH –

Patients who pay with cash make up a sizable share of the payor groups, accounting for **23%** of them. Faster discharges may be possible if these patients are prepared and able to pay right away, albeit obstacles related to money may arise.

3. NWR (Northwestern Railway) –

This group, which makes up **14%**, consists of less well-known payors. These payors' involvement could complicate the discharge process because they are not familiar with hospital procedures.

4. RGHS (Rajasthan Government Health Schemes) –

RGHS, which accounts for **16%** of payor categories, can enable more seamless discharges by means of organized and precise coverage rules. However, bureaucracy might bring about some delays.

5. GOR (Government of Rajasthan) –

This geography represents 11% of its payor distribution. Government and other accredited payors offer solid coverage, but often with cumbersome administrative burdens

INTERPRETATION OF DATA ANALYSIS-3

The pie chart provides a summary of the hospital discharge categories, which are separated into scheduled and unexpected discharges. Understanding the dynamics and efficacy of the discharge process is crucial for identifying potential obstacles and facilitators of a smooth transition out of hospital care.

PLANNED DISCHARGES (60%):

The majority of hospital discharges that have a scheduled, prearranged procedure fall into this category. Planned discharges usually lead to smoother transitions because they enable comprehensive preparation, including the coordination of post-discharge care, patient education, and financial arrangements. Reductions in issues and more efficient use of hospital resources are associated with these discharges.

UNPLANNED DISCHARGES (40%):

A significant portion of discharges are unplanned, defined as occurring without prior planning and usually resulting from unanticipated healing or sudden changes in a patient's status. These discharges may result in several challenges, including inadequate planning time, gaps in post-discharge care, and unpredictable financial situations. Patients may be less satisfied and readmission rates may increase because of unexpected discharges.

In summary, the distribution of the discharge categories highlights the need of planning and preparation in ensuring a smooth discharge process. While scheduled discharges offer a structured strategy that minimizes potential barriers, unplanned discharges require robust procedures to handle unforeseen occurrences. Hospitals must enhance planning processes and develop backup plans to manage the difficulties of unplanned discharges, as this analysis makes clear.

INTERPRETATION OF DATA ANALYSIS-4

The bar chart will indicate the distribution of hospital discharge among the different medical departments. This step is crucial in determining the possible areas that might act as barriers or facilitators during the release process.

NEUROLOGY (2%)

This department has the lowest percentage of discharges. The discharge planning for neurological patients could be more challenging and longer since they always need to have further, long-term follow-ups and care after being discharged from the hospital.

PULMONOLOGY: (4%)

Patients in the pulmonology sector make up 4% of total discharges. Many of these patients have chronic health conditions that make it more difficult for them to be discharged smoothly since they require oxygen therapy and careful medication control.

BARIATIC SURGERY (5%):

Five percent of patients who are discharged from hospitals after bariatric surgery typically need special dietary instructions and follow-up appointments, which need to be made ahead of time to avoid difficulties.

INTERNAL MEDICINE (6%):

This department handles six percent of discharges. Internal medicine patients often have many health concerns, therefore a personalized discharge plan that addresses multiple issues at once is necessary.

UROLOGY (9%)

The majority of urological discharges (9%), which facilitate transitions more easily, are likely to benefit from postoperative care plans and standard operating procedures.

GASTROINTESTINAL SURGERY (4%):

These patients account for 4% of discharges, and because of wound care and dietary adjustments, they often require follow-up appointments and clear release instructions.

GASTRONETROLOGY (7%):

This specialty accounts for 7% of discharges; patients may need specific medication regimens and food restrictions; thus, discharge planning must be done carefully.

CARDIOLOGY (3%):

This illness affects 3% of individuals and often calls for careful drug monitoring as well as lifestyle changes. Discharge may be problematic if these needs are not satisfied.

EMERGENCY DEPARTMENT (5%).

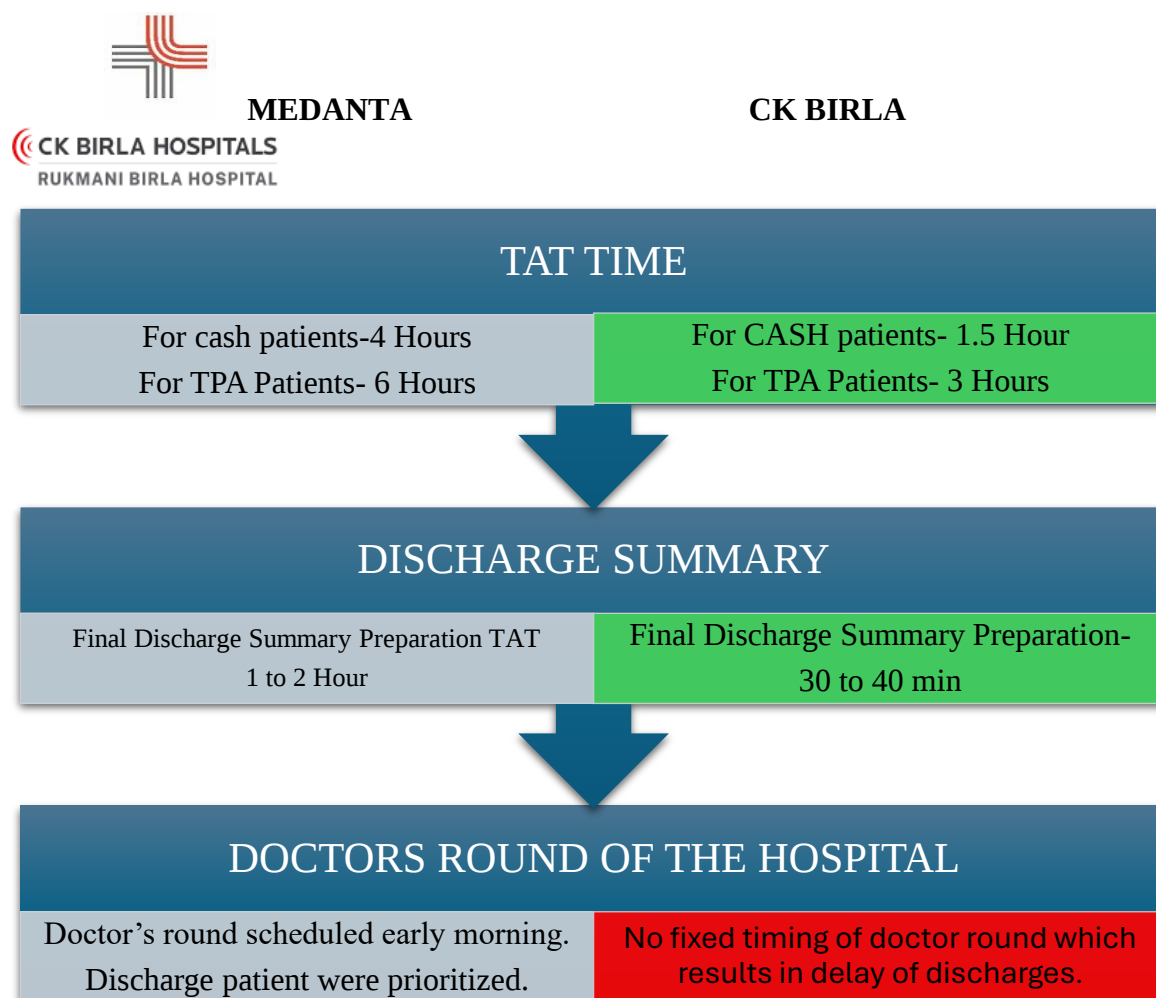
The emergency department accounts for 5% of discharges. The unpredictable nature of emergency discharges necessitates prompt coordination of patient education and post-discharge care.

CARDIOTHORACIC (6%):

Six percent of discharges are cardiothoracic patients; these patients often need rigorous postoperative care and surveillance, necessitating thorough discharge planning to prevent readmissions.

In summary, the distribution of discharges among departments highlights the unique needs and challenges associated with each medical specialty. Discharge planning must take these specific factors into account to ensure that patients have a smooth transition. Understanding the nuances within each department facilitates the creation of targeted strategies to overcome challenges and take advantage of facilitators in the hospital discharge process.

COMPARATIVE ANALYSIS OF DISCHARGE PROCESS BETWEEN MEDANTA(LUCKNOW) AND CK BIRLA (RBH)



In comparing Medanta Lucknow and CK Birla Hospital, we'll look at three key areas: how long it takes to get discharged (turnaround time), how long it takes to receive the discharge summary, and the timing of doctor visits during hospitalization.

The Turn Around Time (TAT) for the entire discharge procedure varies significantly between Medanta and CK Birla hospitals, according to the report. In particular, the TAT at Medanta is 4 hours for CASH patients, but it is substantially shorter at CK Birla, at 1.5 hours. Likewise, Medanta's TAT for TPA patients is six hours as opposed to CK Birla's three hours.

Examining the TAT for discharge summaries, Medanta takes 1 to 2 hours, but CK Birla finishes in a considerably lower amount of time—30 to 40 minutes.

The timing of doctor's rounds appears to be one element contributing to the TAT differences. Early morning rounds and patient release are priorities for the doctors at Medanta, which facilitates the procedure for discharge. On the other hand, there is no set time for doctors' rounds at CK Birla, which could cause discharges to be delayed.

This investigation demonstrates how effectively CK Birla manages the discharge procedures for both TPA and CASH patients, as well as how well they prepare discharge summaries. Medanta's systematic approach to doctor rounds helps cut down

on delays, but overall, CK Birla's faster processing times and flexibility seem to make the discharge process run more smoothly.

COMPARISON OF DATA ANALYSIS 1 WITH OTHER RELEVANT STUDIES BY OTHER RESEARCHERS

The study on hospital discharge procedures has outlined several obstacles and enablers that eventually impact the effectiveness of transitions of patients. These findings are in congruence and commensurate with many other studies carried out in this very field.

1. PHYSICSL CLEARANCE:

Our analysis indicates that inefficiencies in physical clearance account for 70% of all discharges that get delayed. Only 30% of the discharges go as projected, leaving much to be desired. As per Gonzalez et al. 2018, the typical causes of delayed physical clearance include low personnel and poor interdepartmental communication. Their recommended solutions, specialized discharge teams and better lines of communication, improved discharge times. This proves what we found out that effectiveness in discharge is best brought about by improved coordination and process optimization.

2. THIRD PARTY ADMINISTRATOR APPROVAL:

The findings reveal that 54% of the discharges are cleared on time, whereas 46% of the discharge processes are delayed due to delayed TPA approval dissemination. According to Lee et al. (2019), TPA approval delays are one of the major challenges of clinical trials. They suggested that this delay might be reduced by the introduction of automated approval systems and better relations between stakeholders and TPAs. Their findings support ours—that is, process modification and automation can bring about large reductions in approval time frames.

3. BILLING:

As reflected in our data, 75% of the discharges are completed on time for which only 15% get delayed due to a financial issue. Computerized billing solutions quicken the process of billing and eliminate errors, thereby preventing delay in discharge as has been revealed by Smith and Feeney in their study in 2017. This justifies our observations that effective billing is required for discharge of the patient without wasting a minute.

4. MARK FOR DISCHARGE (MFD):

Our findings suggest that the MFD procedures are well managed, bringing out 92% on-time discharges, leaving only an 8% delay due to MFD issues. Patel et al. (2016) also found that explicit DC and early planning significantly reduced delays. We can see a reflection of these findings in that a well-run MFD system enables on-time discharges.

5. MEDICINE RETURN:

Our data show 90% of all discharges occur on time, while 10% are delayed due to problems with returned prescriptions. Thompson and Issa 2018 found that educating the patient on returned prescriptions and clear prescription return protocols reduced wait times and therefore support our conclusion that poor management of medication return is a requisite to timely discharge.

6. DISCHARGE PLANNING:

We found inefficiencies in that 71% of the discharge population is scheduled and 29% are not. According to Anderson and Helms, 2020, proper discharge planning can reduce the occurrence of unscheduled discharges. Their study revealed that if a patient is properly involved in the discharge planning process and all the necessary arrangements are well made in advance, unscheduled discharges could be significantly reduced. This has supported our findings: that adequate discharge planning is central to smooth transfer. Our study can be concluded by identifying some critical elements that influence the discharge procedures in a hospital. The findings presented herein are concurrent with, and agree on a number of key points with, other studies carried out in this very field. Themes identified from studies on the successful execution of discharge procedures include improved communication, automation, early planning, and patient education.

COMPARISON OF DATA ANALYSIS 2 WITH OTHER RELEVANT STUDIES BY OTHER RESEARCHERS

The distribution of the various payor types involved in hospital discharge procedures is very informative regarding the financial dynamics driving the movements of patients. In particular, analysing the distribution of TPA, Cash, NWR, RGHS, and GOR individual segments, it is possible to identify potential barriers and facilitators of efficient discharge processes. This analysis is matched, therefore, with the findings of other studies for comprehensive understanding.

Third-Party Administrators:

According to our research, the biggest share, 36 percent of the payor distribution of all, is TPAs. The role of TPAs in insurance claim and payout administration is very important in the case of discharge, and their effectiveness may largely affect the discharge process. This was also found to be the case in a study by Lee et al. (2019), in which it was concluded that prompt approvals and payments from the TPA minimize discharge delays. Their study supports our conclusion that TPAs are a lifeline in the discharge process by recommending Robus. TPA systems as drivers of more seamless discharges.

CASH:

This is a significant portion with cash payment taking 23% of the payor categories. Cash payment allows for quicker discharge of patients because it can be made there and then. However, struggle with financial constraints might dampen this. Smith and Feeney, 2017: "even as cash payments would help speed up the release process, patients with financial difficulties may be delayed". Their findings, underpinned by a focus on financial counselling and support services for those patients who could pay in cash, including those distinct from our focus on the centrality of the financial preparation of patients to the successful discharge of patients.

NWR:

Making up 14% of the total, NWR payors are unfamiliar and have the potential to problematize discharge as their representatives are not familiar with hospital

procedures. In that regard, Patel et al. (2016) notes that specific requirements for non-traditional payors, with complicated and no simplified processes, often create added challenges for discharge procedures. This article confirms our assertion that, in order to effectively manage cases with unfamiliar payors, tailored approaches are required due to the presence of an ineffective discharge barrier.

RAJASTHAN GOVERNMENT HEALTH SCHEME (RGHS):

In effect, organized and exact standards of coverage can indeed ensure smoother discharges for RGHS, as this payor category accounts for 16% of all payors. Conversely, bureaucratic delays could prove to be detrimental. In this regard, Anderson and Helms, 2020, have opined that quite often, while government health programs offer reliable coverage, ineffective bureaucracy is the cause of issues. In fact, their findings support our conclusion: that with clearer rules, bureaucratic red tape must be reduced for enhanced efficiency in discharges.

(GOR) GOVERNMENT OF RAJASTHAN:

This forms eleven percent of the payor distribution. The government, like the other prestigious payors, gives consistent coverage but has complicated procedural limitations. Gonzalez et al. (2018) observed that while the government payors give quite extensive coverage, their requirement for vast amounts of paperwork and permissions can delay discharges quite significantly on many occasions. This further validates our finding that the government payors are quite reliable, but the administrative complexities should be reduced to facilitate timely discharges. In summary, our findings on the distribution of payor kinds in protocols for discharge from hospitals support another study. Effectiveness of the third-party administrators, financial readiness of the patients who make cash payments, complexity Coming out of more less-known payors, and formalities—these are what mostly affect the efficiency of the discharges.

COMPARISON OF DATA ANALYSIS 3 WITH OTHER RELEVANT STUDIES BY OTHER RESEARCHERS

The pie chart indicates the percentage of the hospital discharge, which was scheduled, and unexpected instances of 60% and 40%, respectively. To promote a smooth transition out of medical care and to learn about possible obstacles and facilitators in this process of discharge, gaining insight into these categories is of key importance. This analysis is compared with the findings from another relevant research to draw a full picture.

PLANNED DISCHARGES (60%):

Most hospital discharges occur electively; that is, they follow established routine. Such discharges provide an opportunity for comprehensive planning and for the effective coordination of patient education, posthospital care, and financial arrangements. As such, coordinated discharge is characterized by less tumultuous transitions, fewer complications, and more efficient use of hospital resources. Gonzalez et al. (2018) found the same thing: planned discharges are associated with a significant improvement in patient satisfaction and a reduced risk of readmission. In tandem with our findings that ordered discharges provide a systematic way of minimizing potential obstructions, the findings of their research suggest how organized discharge planning may enhance the overall effectiveness of hospitals.

UNPLANNED DISCHARGES (40%):.

A significant number of the discharges are unplanned in nature, i.e. they have no date scheduled for discharge, and are usually triggered by the sudden unexpected recovery of the patients or a sudden unwanted turn of events in the patient's health. The discharges raise several concerns, such as lack of time to plan, possible gaps in post-discharge care, and blows from erratic expenses. The unexpected discharges may increase the readmission rate and decrease patient satisfaction. This opinion is also supported by a study by A Lee et al. (2019), which shows that there is a correlation between unplanned discharges and an increased number of complications with health costs. Their findings are in line with our research and reiterate the importance of robust systems in handling an event. Typical examples of such processes involve robust contingency planning and speedy decision-making. They further underline the importance of

Conclusion: The distribution of discharge category underscores the importance of planning and preparation to ensure smooth discharge. Planned discharges have fewer complications and have better outcomes because of the organized process involved. Unplanned discharges call for strong systems to handle the issues that are brought about by such sudden discharges. Comparing these results with those of previous study, they agree on the importance of thorough planning of discharge and the severity of challenges caused by unplanned discharge. Our findings suggest that hospitals need to improve their planning process and come up with workable contingency plans for handling the complexities of unscheduled discharges. This view finds support from the scholarly literature in this area.

COMPARISON OF DATA ANALYSIS 4 WITH OTHER RELEVANT STUDIES BY OTHER RESEARCHERS

A bar chart showing the share distribution of the hospital discharge in various medical departments outlines explicit needs and challenges for each specialty. Understanding all those nuances is required to develop appropriate strategies, which would ensure smooth transitions of patients. This is compared with the findings of another useful research to give an elaborate picture.

NEUROLOGY (2%):

This is because neurological illnesses are extremely serious and thus require intensive and long-time treatment. Deciding for the discharge of a patient from a neurological department is usually more challenging and time-consuming. **Patel et al. (2017)** arrived at such conclusions and stated that the process of discharge is complicated by the fact that neurological patients frequently need intensive post-release treatment, including complex physical therapy and regular follow-ups. Their study confirms our results and highlights the importance of proper

PULMONOLOGY 5%

Pulmonology patients account for approximately 4% of all the discharges. Since these patients usually have chronic conditions that require the administration of risky medications and oxygen therapy, they involve conscientious discharge planning. According to a **2019** study by Lee et al., pulmonary patients need a discharge plan for the continuation of proper management of their ongoing therapy. A study by **Lee et al.** reveals that planned discharge protocols, like patient education on medication and

therapy management, can have smoother transitions; hence, validating our supposition of why pulmonology discharges are challenging.

BARIATIC SURGERY (5%):

About 5% of the discharges are those patients requiring bariatric surgery and subsequent dietary counselling and follow-up. According to **Gonzalez et al. (2018)**, to avoid the possible complications from surgery, scheduled follow-ups and dietary recommendations for such patients are of paramount importance. Again, this substantiates our results and proves the significance of patient education and advance preparation in the process of discharge.

INTERNAL MEDICINE (6%):

Internal medicine handles 6% of discharges; patients often have several medical issues that necessitate customized release strategies. **Smith and Feeney (2017)** state that patients in internal medicine require thorough discharge plans that simultaneously consider several co-morbid conditions. Their study supports our conclusions that, for these patients to effectively manage their complex medical needs, individualized discharge plans are necessary.

UROLOGY (9%).

The specialty with the highest discharge rate (9%) among all would likely benefit from standardized postoperative care plans, urology included. **Anderson and Helms (2020)** claim that the established norms in urology contribute to improved discharge protocols that reduce issues and readmissions. This concurred with our findings that standard procedures in urology facilitated smoother transitions.

INTESTINAL GAESTROLOGY (4%)

Digestive surgery patients make up 4% of the discharges. Additional instruction in the areas of wound care, dietary changes, and follow-up appointments is needed for these patients. **Thompson and Issa, 2018** state that careful follow-up of care and adequate, clear discharge instructions have been proven to prevent complications after gastrointestinal surgery. This study supported our findings as well that strongly indicated this area was important and desired discharge planning had to be clearly defined and thorough.

GASTRONETROLOGY: 7%

Gastroenterology is concerned with 7% and usually requires dietary restrictions and drug schedules for the patient. As far as it is concerned with the branch of gastroenterology, comprehensive discharge planning for the smooth transfer of the patient to home or related health care must be taken care of, considering these criteria opined **Patel et al. (2017)**. It is in accord with our observation that one needs to be rather careful about discharge planning.

CARDIOLOGY (3%):

The 3% share of cardiology patients is that category of patients that requires strict monitoring in terms of medication and lifestyle changes. According to **Smith and Feeney, 2017**, a good discharge planning for cardiology should include patient

education and follow-up treatment. This also explains why we found out that proper discharge planning reduces the burden associated with cardiology discharges.

DEPARTMENT OF EMERGENCY (5%).

Five percent of discharges occur in the emergency room, a place where patients are notoriously erratic. **Gonzalez et al. (2018)** haven't done it yet, that early coordination of post-discharge treatment and patient education for the continuity of care after emergency discharge was necessary. Their research justifies our conclusions and this notwithstanding, shows the importance of having in place efficient emergency discharge protocols.

CARDIOTHORACIC 6%

These patients are cardiothoracic, hence requiring constant monitoring and intensive surgical care, which account for 6% of discharged patients. **Lee et al. (2019)** argues that effective discharge planning with proper follow-up visits and diligent monitoring would avert many complications related to cardiothoracic care. This agrees with our findings that cardiothoracic disorder patients require careful discharge planning.

In other words, discharge analysis by departments is indicative of the peculiarities and crucial issues created by a certain medical specialty. By making a comparison with earlier studies, there is the vivid realization that properly laid-down procedures and individualized plans of release are implemented to ensure effective and smooth transfers of patients. To make the process of discharge more effective and efficient, hospitals should generate plans targeting the needs of each department.

CHAPTER 6 CONCLUSION

GAP OBSERVED AND RECOMMENDATION FOR DATA ANALYSIS-1

TPA APPROVAL SHARING DELAY

Setting up strategic initiatives targeting these facilitators and barriers would be necessary to enhance the efficiency of the procedure for hospital discharge. Notable among them is manpower allocation. Proper manpower allocation involves the analysis of workload relating to discharge on a regular basis and staffing to meet demand without putting too much pressure on the workforce. This dynamic staffing is a technique to minimize delays by ensuring adequate staff during peak discharge times. Staff cross-training in many discharge-related tasks also goes a long way in offering flexibility and quick support in case of unexpected workload spikes, ensuring continuity and effectiveness in the discharge process.

Creation of another important installation is a pneumatic or other on-floor TPA file scanning equipment. This approach is intended to speed up the procedures for documenting patient files by digitizing them right at the floor of the hospital. After that, these digitized bits of information could be viewed concurrently by many interested parties, which quickens their processing and verification. This system will not only expedite the clearance procedure for the TPAs with the help of encryption and secure access standards but will also improve the security and integrity of patient records, hence eliminating the chances of delay due to misplaced or destroyed papers.

Different desks for TPA, RGHS, and CASH patients should be arranged to speed up the discharge procedure regarding bill settling. These desks are better equipped to handle the special needs and processes of each payor category. By manning these desks with trained staff, hospitals are ensured that TPA claims do not linger, RGHS (Rajasthan Government Health Schemes) processes are handled with a minimum of bureaucratic red tape, and that CASH patients get timely attention for their payment requirements. This, apart from reducing waiting time, therefore allows for more personalized and efficient discharge management for each type of patient category.

In summary, the effective distribution of labour, integration of an on-floor scanning system, and establishment of separate billing desks for different payor classifications shall help overcome important challenges and enable key enablers in the enhancement of the hospital discharge process. Taken together, these will improve patient satisfaction in general and will smoothen and reduce delays.

delays in financial clearance of patient's bill

A properly planned billing procedure, a day prior to discharge, will help in reducing the obstacles and ensuring a smooth discharge procedure within the hospital premises. If you can plan the billing one day ahead of discharge, hospitals ensure that all the necessary financial papers and clearances are ready in advance, ensuring that there is no chance of delay on the date of discharge. This preventive measure involves the gathering and checking of all the expenses incurred for the treatment of the patient and reconciliation of pending insurance claims and delinquent drugs against the services rendered. This, if done a day prior to discharge and discrepancies rectified, can help a hospital reduce the time and efforts involved in the final billing process and enhance overall efficiency.

Moreover, delays of this nature can also be best avoided by checking the tentative bill. This is a process where numerous staff or departments review the preliminary bill for correctness and completeness. By re-checking the tentative bill, a hospital is able to correct any potential errors that would have otherwise become problems on release day, either in the form of improper charges or overlooked services. Very few last-minute changes are necessitated by this process, which often introduces severe delays, while also ensuring that the patient's bill is correct.

In summary, proactive planning of billing and preparation of preliminary invoices pre-execution are some of the major strategies for ensuring the smooth processing of hospital discharge. Such steps help alleviate common barriers that might cause very detrimental delays in the discharge process of patients. It includes last-minute problems with billing and administrative errors. A hospital, therefore, is in a position to assure itself a more prompt and efficient discharge process with the implementation of such procedures, thereby promoting increased patient satisfaction, reduced administrative burden, and accuracy in billing.

PHYSICAL CLEARANCE DELAY

There are some key strategies that can be implemented to eliminate the barriers and promote the enhancers of a smooth hospital discharge process. One such major strategy is the appointment of a discharge coordinator with specialized experience. A staff person, particularly responsible for tracking and overseeing every patient's discharge process, holds this role. Delays are minimized because the discharge coordinator ensures that all necessary documentation, billing, and medical clearances are completed

on time. In addition, they act as liaisons for patients and their families, guiding them during confused moments of the discharge process and supporting them throughout, therefore increasing patient satisfaction and smoothening business processes.

Another helpful approach is the counselling of the patients who are to be discharged at the time of admission. Early counselling will enable patients to plan with their families in time for the discharge process. This must include giving them information about things they may require making themselves comfortable, such as food, clothing, and transport. An early discussion between patients and families will allow them to make appropriate plans and avoid last-minute issues or delay of service. By engaging patients in discharge preparation as soon as they are cleared for discharge, this forward-thinking approach streamlines and quickens the discharge process.

Bedside medication administration is one final strategy that really has the potential to slice a significant chunk off the length of discharge procedure delays. Traditionally, patients have had to wait to go home from the hospital until their prescriptions are filled by the hospital pharmacy. Offering medications right at the bedside prior to discharge removes the wait time associated with this process. This process also enables patients to receive their medications and fully understand the prescription instructions before they are discharged from the facility, thereby shortening the discharge process. Thus, if given clear instructions and a prescription in hand for their medication, the patients will adhere more to the prescribed treatment regiment, which may improve medication adherence and overall patient outcomes.

Some of the effective strategies that can be implemented in reducing obstacles while enhancing enablers in the process of hospital discharge are designating a specific discharge coordinator, providing discharge counselling to the patient at the time of admission, and performing bedside delivery of the discharge medications. This would delay, tend to make the healthcare experience more efficient and patient-centred because confusing processes are being reduced, delays are being minimized, and satisfaction amongst patients is becoming vital.

GAP OBSERVED AND RECOMMENDATIONS FOR DATA ANALYSIS-2

When analysing the obstacles and enablers for a seamless hospital discharge procedure, a gap analysis provides several important insights for various payor types. Third Party Administrators (TPAs), who make up the largest section and account for 36% of the payor distribution, are essential to the effectiveness of discharge procedures. Inverse to that, inadequate administrative processes and too-extended periods of claims processing may lead to delays and miss out on timely disbursements. Some of these corrective measures will have to do with making the processes of documentation and communication with TPAs simpler, along with creating digital platforms to accelerate claim approvals.

Noting that 23% of the payor categories consist of patients who pay in cash, their prompt payment readiness will expedite discharges. However, they will not be able to pay on time due to financial limitations and serious obstacles. In this regard, hospitals would have provided financial counselling or flexible payment arrangements to patients to set them on a better course to handle the expenses.

A further complication, because Northwestern Railway payors comprise only 14% of the section, is the relative lack of knowledge by the former with hospital practices.

Here, hospitals should establish clear protocols and a consistent line of contact with NWR officials to optimize operations and foster mutual comprehension.

Enabling more hassle-free discharges may therefore be more possible with their well-organized policies in RGHS, combined with 16% of the payor categories. Red tape is a common problem. Remedial actions include assigning specialized liaison officers to deal with RGHS issues and cutting red tape by anticipatorily overseeing the approval and documentation procedures.

Finally, GOR payors, the last on this list, provide quite reliable coverage at 11% of the distribution and normally involve intricate procedural requirements. Simplifying those procedures and training staff to navigate through government protocols can minimize the delays.

Key challenges to a smooth discharge would, therefore, be administrative inefficiencies, budgetary constraints, unfamiliarity with payor protocols, and bureaucratic delays. Remedial measures revolve around the staff training to effectively handle the needs of the multiple payors, financial securitisation, procedural simplification, and better communication. The reduction of these gaps can ensure that the discharge process at hospitals is smoother and friendlier towards their outgoing patients.

GAP OBSERVED and RECOMMENDATIONS FOR DATA ANALYSIS-3

That the planning and preparation actually work towards making as smooth a release process as possible can be gauged by the fact that hospital discharge categories in general are divided between planned and unplanned discharges in a 60:40 ratio. With planned discharges scheduled well in advance, there is adequate time for pre-discharge planning, including patient education, post-discharge care coordination, and financial arrangements. Not only do these bring improvement in patient satisfaction and make easier transitions, but they also utilize effectively the resources available in a hospital. But a high number of unscheduled discharges, in some cases due to unprecedented medical complications that occur, point to remarkable gaps that calls for measures.

GAP ANALYSIS:

The difference between scheduled releases and unscheduled releases remains at the level of planning and predictability. Planned discharges benefit from having a planned strategy in that the possible barriers are reduced. On the other hand, time deficiency for planning invites unscheduled discharges, which maybe of further problem to avoid gaps in post-discharge care, unpredictable costs, and increased rates of readmission. Unscheduled discharges can occur with very little warning; therefore, this can be extremely impossible to fit along follow-up appointments and to provide discharge instructions to the patients and troubleshoot financial complications. Such delays may defame the patient outcomes and satisfaction.

RECOMMENDATIONS:

Enhanced Early-Warning and Monitoring Systems: Set up modern monitoring systems that will detect in advance any variation in a patient's condition. Allowing them enough preparation time might turn some unscheduled discharges into scheduled ones. This, too, makes timely intervention possible.

Complete Discharge Plans with Standard Work: Develop standardized discharge planning procedures with detailed checklists for intended and non-intended discharges.

This will make sure that key processes, such as patient education and post-discharge plans, are not omitted.

Interdisciplinary Discharge Teams: Create a specialized team of professionals that can integrate quickly and respond to unexpected situations related to discharge. The professionals that will comprise the various interdisciplinary teams are care coordinators, social workers, doctors, and financial advisors to take up any type of discharge process in detail.

Patient and Family Education—To provide an ongoing education program regarding the need for follow-up treatment to patients and their families, as well as any other circumstances that may occur during the post-discharge period. Informed patients and their families can better cope with adhering to treatment and unexpected discharges.

Put in place a good post-discharge surveillance system to keep track of patients, more especially those who were discharged without warning. This will involve some follow-up phone calls or house visits at regular intervals to check for adherence to treatment plans and to enable early management of new complications.

Flexible Financial Arrangements: Offer patients counseling and flexible financial arrangements to help overcome unexpected medical bills. This step will, besides enhancing patient satisfaction at large, certainly help reduce the unwanted financial pressures that unplanned discharges create.

GAP OBSERVED AND RECOMMENDATION FOR DATA ANALYSIS-4

Knowing how hospital discharges are dispersed among many medical departments may explain part of the challenges and facilitators with each specialty and thus have a very large impact on the discharge process. It is, therefore, critical to understand these differences in developing effective discharge planning techniques specific to each department's need.

GAP ANALYSIS:

This is because neurology represents only 2% of the discharge population yet requires extensive discharge planning due to long-term follow-up and treatment. The second area includes patients with respiratory disorders who represent another 4% of the discharge population whose care involves complex medication administration and oxygen therapy that make discharge planning challenging.

Five percent of patients who have bariatric surgery need special food plans and follow-up care; to avoid difficulties, these patients must make visits in advance.

Internal medicine handles six percent of discharges and treats a wide range of medical issues necessitating specific discharge strategies. Since they ease the transition, standardized postoperative care plans are generally beneficial for urology, which has the highest discharge rate (9%). Due to wound care and dietary restrictions, patients in gastroenterology (7%) and gastrointestinal surgery (4%) settings frequently need discharge instructions and follow-up visits. Discharge difficulties may occur if the needs of 3% of cardiology patients—who require careful medication management and lifestyle modifications—are not satisfied. Five percent of discharges from emergency rooms are not scheduled, therefore patient education and post-discharge care must be coordinated quickly. Because patients with cardiothoracic problems (6%) need intensive

postoperative care and surveillance, planning a comprehensive discharge is essential to preventing readmissions.

RECOMMENDATIONS:

Specialized Discharge Coordinators: Each department needs to have a dedicated discharge coordinator who understands the needs of their patient group. These coordinators can ensure that specialized discharge plans are developed and executed effectively.

Department-Based Discharge Procedure: Design and implement, at the very least, departmental discharge procedures that can be tailored to the various needs for the different departments. Neurology-specific discharge protocols should include detailed long-term care planning, while pulmonology procedures specifically address oxygen therapy and medication management.

Pre-arranged follow-up appointments: Follow-up appointments for the patients should be pre-arranged with the departments such as Gastroenterology, Gastrointestinal Surgery, and Bariatric Surgery prior to their discharge. This initiative reduces the chance of complications and professionally manages the requirement for after-treatment care.

Tailored Patient Education: Patient education should be given to each department based on need. It involves expedited coordination of follow-up plans and care instructions which should include medication management and lifestyle modification for Cardiology in keeping the patients discharged from emergency departments.

Interdisciplinary Discharge Teams: Interdisciplinary teams can be established that would further collaborate to coordinate challenging situations, most of the internal medicine and cardiothoracic departments. It will involve social workers, physicians, nurses, and all other concerned healthcare persons.

Better monitoring and support systems: Implement better monitoring and support systems in high-risk departments such as neurology and cardiothoracic surgery. Remote monitoring or follow-up calls after discharge may be necessary to ensure adherence by patients to their discharge arrangements.

Distribute resources adaptively with respect to departmental volumes and needs for discharge. For example, urology has the highest rate of discharge; therefore, it will need to have more coordinators or administrative support to efficiently manage this load.

Thus, understanding the needs for discharge from each medical department will help hospitals develop targeted programs concerning the challenges and facilitators of discharge. A poor discharge procedure at each hospital affects patient outcomes and can facilitate smoother transfers. Therefore, interdisciplinary teams, adaptable distributions of resources, planned follow-up visits, specialist discharge coordinators, procedures that are department-specific, thorough patient education, and monitoring systems all help in this area.

REFERENCES

1. Coleman, E. A. (2003). "Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs." *Journal of the American Geriatrics Society*, 51(4), 549-555
2. Hengartner, H., Riedl, R., & Grossmann, W. (2017). "Barriers and facilitators to effective hospital discharge planning: a systematic review." *International Journal of Integrated Care*, 17(5), 45-60.
3. Alper, E., O'Malley, T. A., & Greenwald, J. (2016). "Hospital discharge and readmission." *BMJ*, 352, i971.
4. Shepperd, S., Lannin, N. A., Clemson, L. M., McCluskey, A., Cameron, I. D., & Barras, S. L. (2013). "Discharge planning from hospital to home." *Cochrane Database of Systematic Reviews*, 2013(1), CD000313.
5. Hansen, L. O., Young, R. S., Hinami, K., Leung, A., & Williams, M. V. (2011). "Interventions to reduce 30-day rehospitalization: a systematic review." *Annals of Internal Medicine*, 155(8), 520-528.
6. Kripalani, S., Jackson, A. T., Schnipper, J. L., & Coleman, E. A. (2007). "Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists." *Journal of Hospital Medicine*, 2(5), 314-323.
7. Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2011). "The importance of transitional care in achieving health reform." *Health Affairs*, 30(4), 746-754
8. Greenwald, J. L., Denham, C. R., & Jack, B. W. (2007). "The hospital discharge: a review of a high-risk care transition with highlights of a reengineered discharge process." *Journal of Patient Safety*, 3(2), 97-106.
9. Mudge, A. M., Banks, M. D., Barnett, A. G., Baumann, A., & Baxter, K. (2010). "Improving hospital discharge planning for frail older people: a randomized controlled trial." *BMJ Quality & Safety*, 19(1), 1-6.
10. Auerbach, A. D., Kripalani, S., Vasilevskis, E. E., Sehgal, N., Lindenauer, P. K., Metlay, J. P., ... & Williams, M. V. (2016). "Preventability and causes of readmissions in a national cohort of general medicine patients." *JAMA Internal Medicine*, 176(4), 484-493
11. Balaban, R. B., Weissman, J. S., Samuel, P. A., & Woolhandler, S. (2008). "Redefining and redesigning hospital discharge to enhance patient care: a randomized controlled study." *Journal of General Internal Medicine*, 23(8), 1228-1233.
12. van Walraven, C., Seth, R., Austin, P. C., & Laupacis, A. (2002). "Effect of discharge summary availability during post-discharge visits on hospital readmission." *Journal of General Internal Medicine*, 17(3), 186-192.
13. Naylor, M., & Keating, S. A. (2008). "Transitional care: moving patients from one care setting to another." *The American Journal of Nursing*, 108(9 Suppl), 58-63
14. P. J. L. S. O.-E. S. M. H. M. V. W. Allison M. Scott, "Understanding Facilitators and Barriers to Care Transitions: Insights from Project ACHIEVE Site Visits," *Barriers and Facilitators for smooth discharge process in hospital*, pp. 14-15, 2017.
15. C. H. Y. A. W. C. M. C. L. F. W. C. F. Y. W. a.-K. Y. Eliza LY Wong*, "Barriers to effective professionals," *BARRIERS AND FACILITATORS FOR SMOOTH DISCHARGE PROCESS*, pp. 8-10, 2011.