

Spot delays early. Move patients sooner. Reduce readmissions.

A residency-integrated HM model that clears bottlenecks, shortens stays, and protects capacity.

KEY TAKEAWAYS[†]

12.3% shorter observation stays: Brief daily huddles surfaced barriers early and prompted same-day fixes.

Shared purpose across the team: A short resident learning series tied social drivers and core metrics to everyday decisions, building consistent habits.

Simple workflow, fewer readmissions: A repeatable discharge process aligned hospitalists, case management, and pharmacy—supporting a readmissions observed-to-expected (O/E) of 0.8.

Plan discharge from day one: Clear criteria and proactive coordination increased anticipated discharge flags by 8% and sent 80.2% of patients home.

PROBLEM

Post-Covid pressures drove throughput and length of stay (LOS) challenges: nursing shortages, emergency department (ED) boarding, unexecuted orders, and discharge delays tied to authorization. Two gaps amplified issues:

- Limited, consistent visibility into barriers to discharge across teams
- Residents not routinely trained on LOS, readmissions, or discharge operations

SOLUTION

Sound partnered with case management and the internal medicine residency to make delays visible and actionable:

- **Multidisciplinary rounds with a discharge lens:** Daily huddles reviewed diagnosis, milestones, and next-site-of-care needs (transport, home support, primary care provider (PCP) access).
- **Readmissions risk workflow:** Risks flagged on admission; PCP confirmed/established; pharmacy residency prepared discharge recommendations; brief debriefs for any readmission.
- **Avoidable delay tracking:** Real-time identification (studies, consults, authorization) with owners assigned the same day.
- **Residency education:** Short curriculum linking social drivers to LOS/ cost and defining core metrics (LOS O/E, readmissions O/E, discharge before noon).

RESULTS[†]

12.3%	reduction in observation LOS
2.2%	improvement in LOS O/E
+8%	in anticipated discharge flagging
0.8	readmissions O/E
80%	of patients' next site of care: home

[†] Site-reported operational data validated by Sound Business Intelligence & Analytics (BIA). Extracted from Sound Metrix and HM Hospital Tabular for January 2023-April 2024. Results reflect this partner program during the stated period and may vary by hospital.

WHY IT WORKED

We paired residents with the care team and added a brief daily check-in to spot discharge hurdles early. Hospitalists, case management, nursing, and pharmacy worked together to help patients get home safely, sooner.

Let's talk about your LOS and discharge goals.

Start a conversation: partnership@soundphysicians.com

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