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INTRODUCTION

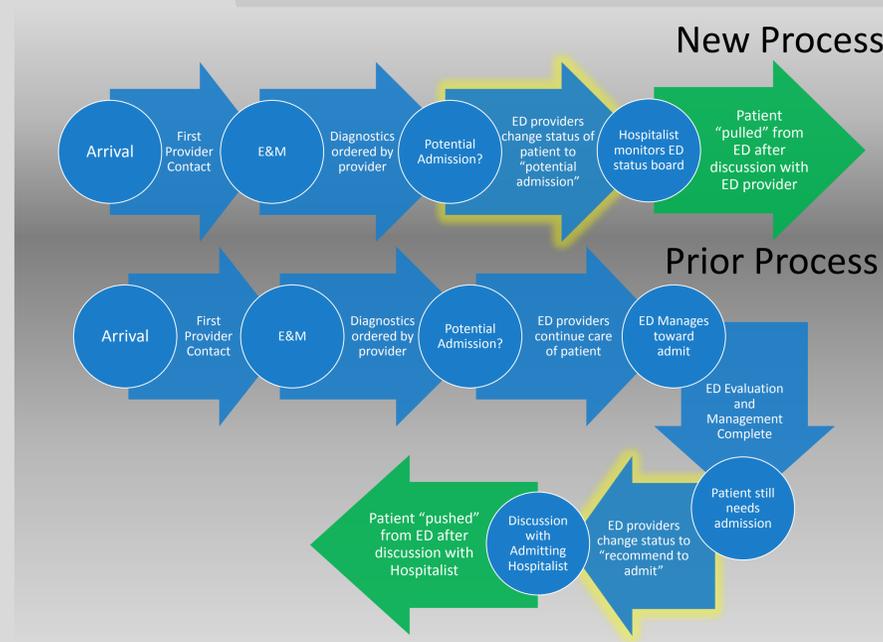
Emergency Department throughput has been referred to as “Emergency Department processes that impact patient flow”. This includes triage, staffing, availability of specialty and diagnostic services, surgical scheduling and information technology resources.” A measure set was developed by CMS and has been adopted by JCAHO and includes quality metrics such as time from ED arrival to ED departure for admitted patients, and admit decision time to ED departure for admitted patients. Quality issues arise from variation, and no one knows the sources of and solutions to variation better than the front-line staff.

INNOVATION

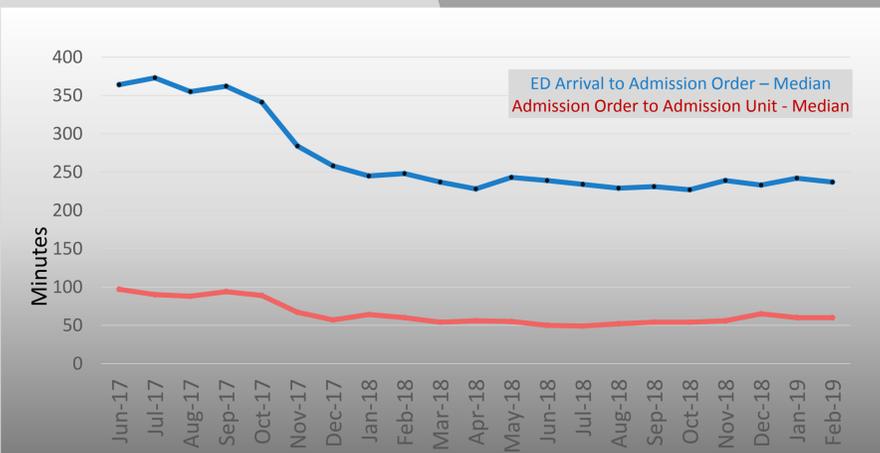
A pilot project was developed for a high-acuity community hospital to indirectly-inform hospital inpatient services of patients considered by the emergency department physicians to be a high-probability for admission. A time-stamped electronic health record (EHR) indicator was created. The emergency department provider designated, as early as they determined, a patient to be a high-probability for admission. Leveraging a more senior-hospitalist physician, the pilot study looked to examine if early indirect communication through an EHR passive indicator could empower the admitting services, during peak hours for patient arrivals in the emergency department, to more readily respond to patient care needs by “pulling” patients that met criteria for admission to the hospital for their presenting problems. By monitoring the ED track board and review of the ED patient flagged as “high-probability for admission”, if the hospitalist agreed and had enough information available for their decision, the flow-hospitalist would contact the ED with any questions advise them of their willingness to “pull the patient” and an admission order would be entered. The patient was transported from the ED with minimal (and sometimes no) required ED-based evaluation.

RESULTS

The pilot began in October, 2017 with data collection for ED arrival to admission order, admission order to admission unit as observed metrics. Through the implementation of this pilot project there was an increase in emergency department provider satisfaction with the admissions to hospitalist services from 27% to 92% in polling of ED providers (physicians, APs, nurses). ED providers of all experience levels (physicians and APs) were accurate in non-criterion based selection of a patient as a “high probability” for admission 92% of the time.



Admission order to admission unit time decreased by a mean time of approximately 32 minutes.



The overall effect on ED arrival-to-admission order interval for emergency department patients decreased by a mean time of approximately 108 minutes. Patient satisfaction with their overall hospital care journey was significantly improved considering this and other innovations implemented simultaneously. There were perceived improvements in the workflow for the hospitalist services due to greater ability to influence the admissions/hour during peak volume demands for patients presenting to the emergency department. It was also noted that early indication for high-probability admission in the emergency department may provide better opportunity to use hospital resources to avoid 30-day readmission in lieu of other management for patients at risk for readmission. The patient satisfaction mean improved 16.6% from 71% to 87.6%.

LESSONS LEARNED

By examining opportunities for improved communication between the Emergency Department and Hospitalists through optimizing opportunities for improved communication through optimizing ED EHR signaling of early identified high-probability admissions, there was observed improvements in ED throughput. In addition, the involvement of clinicians from both departments in developing process changes created change sustainment and a greater understanding of the ability to create non-stop improvements rather than fixes to respond to the ED care environment.

With greater understanding of ED patient status, the admitting hospitalists decreased the need for “ED pushes” of patients associated with daily predictable ED volume fluctuations and improved on the arrival to admission bed time to the satisfaction of patients. By being invested in Emergency Department processes that impact patient flow, admitting hospitalists were able to smooth admissions/hour flow through greater control of “pulling” patients for admission. The collaborative efforts have increased trust and understanding of needs of the ED and Hospitalist services in our community hospital.