Getting the Service Right: Non-Surgical Admissions

The Problem

BIDMC's rate of admission to nonsurgical teams over a 6 month period ranged between 5-21% (July-Dec, 2012) – most months well above the established goal of <10%.

BIDMC holds an American College of Surgery (ACS) Level I Trauma Verification, which promotes and upholds standard around the quality of care, the interdepartmental services and the outcomes of trauma patients.

The ACS requires trauma programs that admit more than 10% of injured patients to nonsurgical services demonstrate the appropriateness of the practice through its performance improvement process (PIP)

Aim/Goal

The aim of the PIP is to develop a consensus based plan for most appropriate surgical service for non-surgical trauma admissions coupled with other service (medicine/gerontology, etc..) consultation within the first 24 hours of admission.

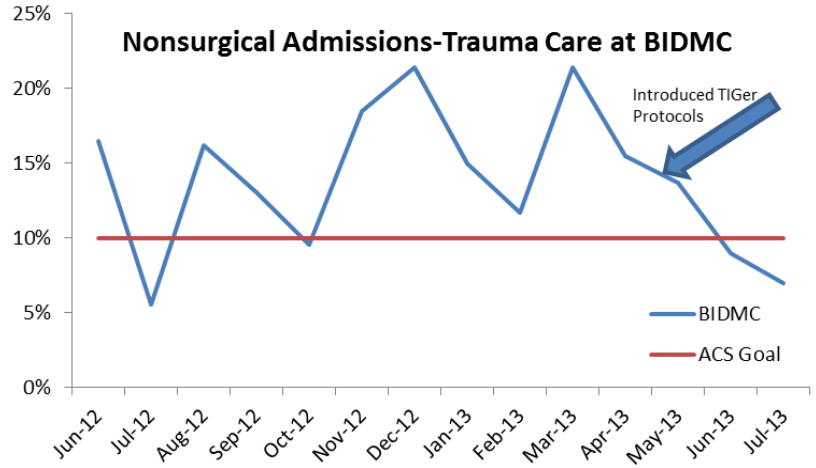
The Team

Carl Hauser, MD FACS – Trauma Medical Director
Julius Yang MD PhD – Director Inpatient Quality/ Hospitalist
Carlo Rosen, MD - Emergency Medicine
Suzanne Hartmann, MD - Gerontology
Darlene Sweet BSN, RN – Trauma Program Manager
Tyler Howrigan, RN – Trauma Educator
Amy Hersom – Trauma Registrar
Monica Nasser – Trauma Admin Coordinator
Larry Markson, MD – Information Systems
Larry Nathanson, MD – Emergency Medicine Information Systems

The Interventions

- Multi department 'look back' at the nonsurgical admissions over a 12 month period to analyze and reconcile the service at admission decision to the injury severity scores, the extent of comorbid or pre-existing chronic conditions requiring medical management, patient age and patient/family goals of care preferences
- Collaborative agreement between surgery services, medical and gerontology services regarding lead vs. consultant role in the complex trauma patient's hospitalization (established the ***TIGER Protocol***)
- Education and Orientation to assessment protocols, appropriate use of consultation provided to residents and hospitalists (ongoing)

The Results/Progress to Date



Lessons Learned

Continuous data collection and regulatory requirement duties benefit from period 'deep dive' to understand trends (positive/negative), any root causes and opportunities. The patient data registries can be useful when interpreted into information that can stimulate and focus action teams

Key principle in process change that added value in this effort was gathering representation from all departments from the very beginning

The ACS standards and expectations acted as very good guide and framework for the process and communication improvements that ultimately support patient-centered care and the right expertise at the right time for each of BIDMC's Trauma patients.

Next Steps/What Should Happen Next

In the upcoming months, the Trauma Program will

- Obtain MEC approval (completed 12/2013)
- Communicate and roll out the TIGER Pathway
- Include Medicine and Gerontology representation at Trauma Care Committees
- Improve the overseeing and reporting of meaningful interpretation of Trauma Registry data at monthly committee meetings
- Perform real time case review of patients not placed in TIGER Pathway

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