Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

# Transferring patients back to community hospitals during the COVID-19 pandemic

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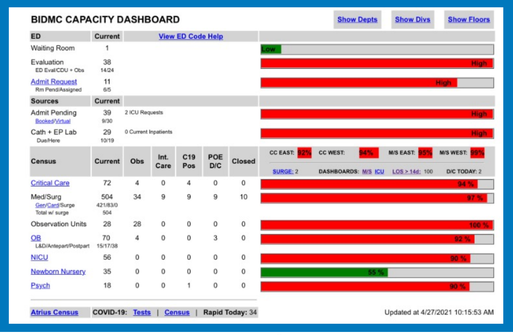
## Introduction/Problem

The BIDMC is the flagship tertiary care center in the BILH network, and operates at or close to full capacity during normal times. During the COVID-19 surge, it was imperative to keep beds open for high acuity medical and surgical patients. We needed to develop a process to return patients to community hospitals when they no longer need tertiary care.




## Aim/Goal

The project aim was to create a standardized process to identify and easily transfer patients back to community hospitals. The goal was 5 successful community hospital transfers/week.

## The Team

- Lauren Doctoroff, MD, MBA- Medical Director, Case Management, Project Lead
- Tracy Lee, RN, DNP- Senior Nurse Director, Case Management
- Sandra Sanchez, RN- Nurse Director, Transfer Center & Bed Placement
- Alicia Clark, MD- Medical Director, Transfer Center & Bed Placement
- Afrin Farooq, MD – Hospitalist, BI Milton
- Margaret Hayes, MD- Medical Director, MICU
- Jordan Ellis- QI Project Manager

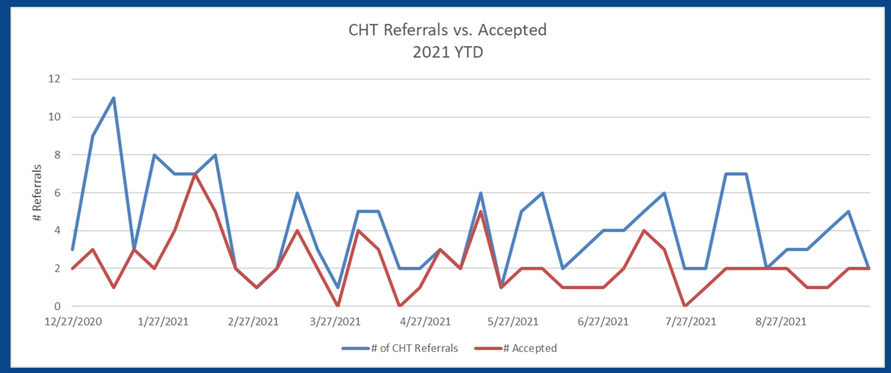
## Lessons Learned

- Needed to engage community hospitals early
- Patient identification early in hospitalization is most important factor
- Community hospital capacity limited growth of program

## The Interventions

- ***Market Research***:
  - Focus groups with patients, survey to physicians, meetings with hospital leadership
- ***Community Hospital Engagement:***
  - BIDMC hospital leadership met with community hospital leadership to set expectations for return transfers
- ***Process Development***:
  - IT: Developed new reports to standardize identification of patients
  - MD leadership engagement: Collaborated with medical directors to create standard process to identify patients through regular distribution of community hospital patient list
  - Standard language: Developed standard language for MDs to use when having conversations with patients and families about return transfers
  - Standard process: Created standard process for identification and patient agreement prior to sending potential transfer to admissions facilitators to reduce rework

## Results/Progress to Date




The above graph shows the community hospital referrals to the transfer center versus the accepted community hospital transfers. We consistently get 3-5 community referrals weekly as this work continues.

***For more information, contact:***

**Lauren Doctoroff, MD**