Beth Israel Deaconess Hospital-Milton

Sustaining Favorable Emergency Department Patient Flow Times following the Closure of a Neighboring Hospital

The Problem

In November 2014, Beth Israel Deaconess Hospital-Milton (BID-M) was formally notified by the state of Massachusetts that a much larger neighboring hospital (Steward Quincy Medical Center, QMC) was closing. This closure occurred following several months of speculation, but without advance confirmation from the leadership of that hospital or its parent company. The final notification was communicated on November 6, 2014, describing closure effective December 31 2014, later revised to December 26, 2014. As a result of this action, QMC would no longer provide acute inpatient medical/surgical services and its Emergency Department (serving a large number of behavioral health patients) would no longer provide the same level of service as it had done previously. BID-M had experienced a 41% increase in ED visits between FY 2007 and FY 2014. Following QMC's closure, BID-M experienced an additional 12% increase in ED volume in FY 2015.

Although BID-Ms ED patient flow times were historically and consistently better than national and state averages, and were particularly favorable in relation to local competitors, there was concern that a surge in ED patients could result in care delays that would adversely impact not only the ED, but other inpatient and outpatient services at the hospital, especially for patients being admitted to the inpatient setting from the ED.

Aim/Goal

Sustain previous performance relative to patient flow times from 'decision-to-admit' to 'time of departure' from the ED during CY 2015 to less than or equal to baseline mean (77 minutes: FY 2012-2013) despite a 12% increase in ED visits.

The Team

- Emergency Department
- All inpatient/outpatient nursing, clinical and support staff
- Medical Staff
- Executive Leadership

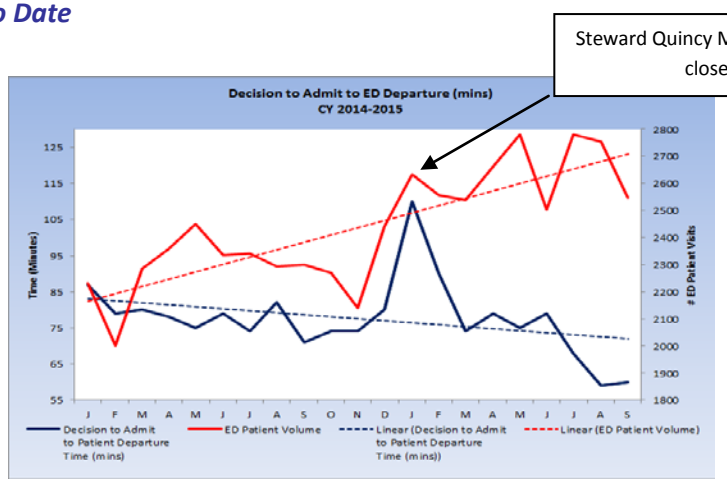
The Interventions (Specific to CY 2015)

- 7% increase in FTE approved positions throughout organization
- Dedicated phlebotomist in the ED
- Simplification of bed assignment process. Elimination of multiple process steps and creation of COP role (Coordinator of Patient Placement) responsible for rapid bed assignment
- Additional four beds (monitored) added to ED (construction) – appropriate for placement and monitoring of behavioral health patients and ED observation pathway patients
- Masters prepared Director, Care Integration position created and hired
- Case Management/Social Worker positions added (ED based)
- Pharmacist hours provided to ED to support medication reconciliation process.
- Electronic SBAR process from ED to IP floors developed by nurse practice council and implemented (provides opportunity for receiver to clarify and ask questions)
- Daily inpatient interdisciplinary rounds developed and implemented to address patient needs and expedite timely patient discharge
- Clinical Nurse Coordinator position developed (IP units and ICU)

The Interventions (Specific to CY 2015)-Continued

- ICU medical intensivist program developed and implemented
- ED *Zone Nursing* leveraged
- 24/7 surgical PA program expanded to support care processes
- Additional in-house hospitalist provider hours added
- Inpatient & ED nursing staffing increased to meet higher patient volume
- Staffing coordinator position created and hired to facilitate nursing resource availability
- Additional transport staff added
- TDSS system purchased an implemented as means to book and track availability of transport/EVS services

Progress to Date



Despite a 12% increase ED patient volume, the data demonstrates that the decision-to-admit to departure time from the ED ('throughput time') for admitted patients has continued to decrease. Following a spike of 110 minutes immediately following the QMC closure, throughput times for 2014-2015 ranged from 59-78 minutes in comparison to 71-87 minutes between 2012 - 2013.

Lessons Learned

The measures implemented positively affected the hospital's performance relative to decision-to-admit to ED departure times. This was achieved in the presence of a significant increase in patient volume for the hospital, not only within the ED, but also in all hospital areas and service lines.

Next Steps

The hospital is currently planning for the implementation of point of care testing in its ED relative to a selection of laboratory tests, with the goal of further expediting patient flow and improving patient experience.

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For More Information Please Contact: *Alex Campbell, MSN, RN, NE-BC, CPHQ, Director HCQ & PS*
alex_campbell@bidmilton.org