Medical Executive Committee
Emergency Department Diversion Reduction Initiative
DRAFT

Background

The SFGH Emergency Department (ED) goes on diversion status nearly every day for some period of time. There are many reasons for diversion including high-volume ED traffic, limited ED space, patient throughput inefficiencies, lack of available inpatient hospital beds, disposition challenges, etc.

ED diversion confers considerable adverse consequences for the enterprise and our patients:

- Financial—reduced revenue, increased costs
- Training—reduced learning opportunities for our student, resident, and fellowship programs
- Disservice to our patients who must receive care at unfamiliar facilities lacking access to their medical information

The organized Medical Staff, through the MEC, is committed to take action to address factors under our control. We have identified two important themes—we must have written policies governing these matters and enhanced attending-level involvement and communication is required. We are targeting high-yield, actionable items.

We have identified 3 key *physician-related* patient flow issues:

1. Delay in writing admission orders—bed available; no orders
2. Disputes among services about who admits the patient—residents traditionally have influenced this process to a great extent with limited attending involvement
3. Holding patients in ED while awaiting diagnostic studies (primarily CT scans)—once a patient leaves the ED, they lose their place in the scanner queue and it can take days to obtain the study, creating an incentive to hold patients in the ED

Action Plans:

1. Holding Orders:

   ED will write holding orders when necessary and send the patient upstairs

   - Routine—90 minute time limit from time of call to admitting team
   - Critical—on diversion or threat of diversion—holding orders will be written immediately upon the decision to admit

   Goal is for the team to evaluate and write orders in ED whenever possible, but patients will not be held in the ED beyond these limits when beds are available upstairs

   We acknowledge concerns about triage decisions and will ensure a mechanism for providing feedback to the ED

2. Admitting service determination:
    A. The ED attending will decide the most appropriate admitting service based on existing guidelines and the primary clinical problem
        - This determination will apply universally to all services
        - The admitting service is determined based on the nature of the problem, not other factors, as determined by the ED Attending
        - Every attempt will be made to select the most appropriate service to minimize later transfers in the interest of patient care and efficiency
        - We acknowledge the ED sometimes won't get it right—the ED and medical staff is committed to monitor and give/receive feedback
    B. Service Attending involvement—if the ED receives push-back by the on-call resident, the ED Attending will page the Service Attending and make a mutually agreeable plan

3. CT Queue:
    The ED Attending now can control the Radiologue queue and will ensure newly admitted patients retain their spot in line when they go upstairs. Admitted patients with a bed assignment will not be held in the ED for imaging studies. They will remain in the ED queue and will be called down to Radiology for their studies according to the queue. The queue is managed by the ED Attending in Charge (AIC).

<u>Monitoring</u>
We recognize these changes in admitting procedures may result in suboptimal outcomes in some situations. Examples include admission to the "wrong" service, inappropriate triage (level of care upstairs), CT scans not completed in a timely manner, and unforeseen unintentional consequences. It is important to monitor the effects of these changes on both patient flow and potential adverse outcomes.

Holding Orders:
1. ED will track holding order use, including notation of routine or critical status determination [denominator]
2. Admitting teams will report adverse effects from use of holding orders (e.g., patient admitted to inappropriate level of care, patient decompensates on unit prior to evaluation by admitting team). These cases will receive a formal review by the Chief of Emergency Services or designee and a designee from the service involved.

Admitting Service:
1. ED will track when they need to call the Service Attending and the outcome of that dialogue (e.g., patient admitted to the original team, another team, or discharged from ED) [denominator and outcome measure]
2. Admitting teams will report when the patient must be transferred to another Service for most appropriate care <24 hrs from admission

CT Queue:

1. ED will track the number of times a patient is sent upstairs while awaiting a CT [denominator]
2. Admitting teams will report instances of delayed CT due to patient losing place in queue

[We need to work out the monitoring details—the ED will develop procedures to log the "denominators" and we will work with Quality Management to have a central reporting mechanism for adverse event reporting ("numerators").]

Additional Monitoring (already in place):

1. Frequency of diversion, hours on diversion
2. Number of admitted patients in ED with beds available and no admission orders

Feedback

Adverse events will be shared with the individual ED attendings and reviewed by the ED Service Chief

Trends in attending response to calls from the ED will be shared with Service Chiefs

Reassessment

Aggregate data will be reviewed monthly by the ED attendings and MEC

Adjustments in the above policies will be made as needed based on outcomes