Level 1or 2: Care Process Executive Summary

Care Process

Select the care process this corresponds to from this dropdown menu:
F.1 Minimize boarding

Your care process name:
Minimizing boarding for geriatric patients in the ED

Date care process approved by your EM Department/Division:
11/21/2023

Description

Describe the population that the care process will apply to and any exemptions. For example, it may apply to all patients over 65 or a subset based on age, ESI, or another positive screening tool. Patients who are severely ill or intubated may be exempted:
This process applies to all patients aged 65 and over who have been admitted to the hospital from the ED (meaning an admission order has been placed) but who have not yet been roomed outside the ED.

Hours of the day when the care process will be implemented or available if applicable:
24/7

Describe where in the ED workflow this care process fits in. For example, it may occur in triage, once the patient is roomed, at discharge, after discharge, after admission, during another transition of care, or other time:
This care process would apply after the decision to admit has been placed in the EMR.

Brief description of the care process. If you are using a hospital-wide process, please explain how it is applied specifically in the ED:
We are pursuing three distinct approaches to reduce boarding for older adult patients.
1. Prioritizing bed placement for vulnerable older patients. The goal of this care process is to identify patients most at risk for medical or psychiatric decompensation or delirium in the ED and prioritize their bed placement. The admitting physician or APP will perform a brief assessment using the following criteria, and if positive and the physician/APP is concerned about potential decompensation (based on clinical discretion), they will send a secure chat through the EMR to the medical/surgical bed placement officer. The bed placement officer (BPO) will then prioritize bed placement for this patient. The screen will include the following items:
-ESI 2
-Unstable vital signs (hypotension, tachycardia, hypoxia)
-Presence of delirium
-Presence of moderate to severe cognitive impairment
-Need for 1:1 sitter for any reason (medical, social, psychiatric, or falls risk).
-Age over 85

We have built a simple, check-box form into our EMR with the brief screening questions to facilitate ease of use and documentation and to allow easier chart review for QI of the process.

2. Reducing ED boarding through increasing throughput and earlier discharge. In addition to these measures in the ED, the hospital will convene a multi-disciplinary Patient Boarding Committee to continue to work to decrease boarding. This committee will consist of representatives from EM, surgical and medical specialties, nursing, case management, social work, transportation, a patient representative, and environmental services. The committee will perform a holistic review of hospital flow processes to identify opportunities for earlier discharges, address bottlenecks in patient flow, such as transportation or room turnover, and will make recommendations to the CMO and hospital president regarding the allocation of resources that will have the greatest impact on reducing ED boarding. While the above measures will help all patients, in combination with the earlier mentioned screening and methods, they will disproportionately have a positive impact for older patients.

This committee will also work with other stakeholder groups to inform the development of alternatives to admission and opportunities for earlier discharge or transfer from the hospital. These options or pathways may include a hospital at home program, transfers to other facilities within the healthcare system, and more efficient pathways for discharge to nursing and rehab facilities.

3. Creation of a surge plan. When hospital capacity reaches a high level and there are >20 admitted patients in the ED, a surg e plan will go into effect, in which inpatient teams will be alerted, discharges prioritized, and patients who are discharged but awaiting transportation home will be provided with a lobby waiting area and meals until their transportation arrives. The surge plan will also involve calling in on-call physicians, nurses, and staff to open all available beds and expedite services if bed availability is limited by staffing. This surge plan team will involve physician, nursing, and case management leadership. The group will meet weekly to assess progress and will perform a monthly audit and report of the impact of its interventions on hospital capacity and ED boarding.

Who will be responsible for performing the actions in the care process:
The initial bedside screen will be performed by the treating physician or APP. The bed prioritization will be performed by the bed placement officer.

Describe how this care process is geriatric-specific:
The screening for bed prioritization will apply only to patients aged 65 and over. The other measures will apply to all patients.

Describe any further follow-up or interventions involved:
The geriatric ED team leadership will perform a boarding audit monthly for the first 6 months, and then move to quarterly audits and reporting once additional changes and iterations have been made. During the first 6 months, the boarding times will be closely monitored and compared with equivalents for the prior year. In addition, the group will monitor for any unintended consequences, such as longer boarding times for other vulnerable groups such as immunocompromised patients. We will continue to hone our criteria for high- and low-risk older patients as our process evolves. We will also review boarding times as it relates to hospital capacity and ED volumes to determine the days or times when most patients are boarding to bring this data to the Patient Boarding Committee.

Education

Describe how you will educate the relevant staff, physicians, or other stakeholders about the care process:

Physicians and APPs will be educated about the new care process during monthly faculty meetings, and through emails.

Monitoring

Describe how you will monitor completion of the care process and its impact, where relevant. The list of GEDA care processes provides details about the required reporting or metrics for monitoring implementation. You should include what measures you will monitor or track. Please clearly indicate the numerator and denominator of measures that you are following. Tracking can be done through a live dashboard of screening results, through periodic random chart reviews, or through other tracking methods. You will have a chance to copy your data below.

We will measure and monitor the following:

1. The boarding time for all older adults, and the boarding time for those that screen positive for our 'high risk' features. We will also compare this to the boarding time for all patients in the ED. Boarding time is measured as the time from placement of the admission order in the EMR, to the time of transport to the floor, step-down, OR or ICU bed. Specific monitoring: Median and standard deviation of boarding time for: all patients, all patients aged 65 and over, high-risk older patients, and low-risk older patients.

2. We have set a goal boarding time of within 4 hours from admission decision. We will monitor times as well as the % that fall within the 4-hour target. We will monitor the % of high-risk geriatric patients who board in the ED for over 4 hours as compared with non-high-risk geriatric patients and all patients. (Numerator: High risk older patients who board over 4 hours, Denominator: All high risk admitted older patients) (Numerator: All older patients who board over 4 hours, Denominator: All admitted older patients)

3. We will also monitor the same above metrics for very long boarding times (over 8 hours and over 12 hours). We will perform monthly audits of these numbers for 6 months, and then quarterly audits to review for patterns or reasons for increased numbers of boarding times over 8 hours and 12 hours.

Describe how often and by whom the monitoring will be performed.

During the first 6 months of this care process, we will assess the metrics above and perform random chart audits to review causes of higher than usual boarding times or higher percentages of older high-risk patients boarding on a monthly basis. We will use the data to hone our system, provide feedback to physicians and staff, and will then perform the monitoring on a quarterly basis in an ongoing manner.

Please describe how you will help improve the rates of completion or impact of the process if rates are currently low or become low in the future.

If we note rates of completion of the screening are low, we will perform targeted intervention and education with physicians and APPs. We will also have an annual reminder at faculty meetings and include the process in the on-boarding packet for new hires. If we note the boarding numbers are rising or median boarding times are increasing, we will work with the hospital-wide committee on boarding to bring them the data and request a further investigation into causes and potential solutions by that committee.

Reporting Data or Process Evidence

Please review the GEDA Care Process description sheet. This will explain what the required metrics evidence that you should submit in support of your care processes. Some care processes require specific metrics

reporting with at least 3 months of tracking data. Other care processes have a range of options you can submit to demonstrate the care process has been implemented. Please copy or screenshot and paste your data or evidence below.

Please do not include any patient protected health information.
You can insert or paste the data directly, or you can screen capture and paste using the following controls:
Mac: Command+Control+Shift+4 to select the area to copy, the paste with Command+V
PC: Win+Shift+S to select the area to copy, then paste with Ctrl+ V