# "CUTTING OUR 'LOS'SES: HOSPITALIST & EMERGENCY MEDICINE MULTIDISCIPLINARY PARTNERSHIP TO IMPROVE ED THROUGHPUT"

Gallagher David MD, Wachter Adam MD, Setji Noppon MD, LaMay Edward MD, Burrows Brian MD, Pickens Andrew MD JD, Gerardo Charles MD, Sawyer Suzanne, Edwards Faith RN, Babb Mitch RN, Griffith Brian MD, Verma Lalit MD

**Background:** Emergency department (ED) crowding is a widespread national issue which has been shown to negatively impact patient experience and the quality and safety of care delivery. A community hospital within our academic health system was experiencing significant ED crowding with long ED length of stay (LOS) and high left without being seen (LWBS) rates.

**Purpose:** To determine the change in ED LOS for patients admitted to the medicine inpatient service after implementation of innovations developed through a collaborative quality improvement project involving hospitalists, ED physicians, and nursing.

**Description:** Our multidisciplinary team focused on reducing the time for the medicine admitting service to provide initial approval for admission or observation of ED patients (ED Consult Response Time). Our intervention had three components:

1. Transition orderset: Prior to intervention, patients would remain in ED until full admission orderset had been completed. Creation and utilization of a transition orderset allowed for efficient clarification of admit status, bed type, diet, activity, and initial nurse care instructions to facilitate transfer of a select group of clinically stable patients from ED to ward. This was followed by the admitting hospitalist or resident completing the clinical evaluation and remainder of admission orders.
2. Education: Ongoing education for hospitalists, residents, and nursing was provided about the transition order set, its usage, and the importance of this work. We instituted regular review of ED LOS metrics at hospitalist faculty meetings and with Hospitalist/ED leadership meetings.
3. Incentives: Incorporation of the ED consult response time metric into the yearly quality financial incentive plan for hospitalist physicians and leadership.

Impact of the interventions was assessed by comparing summative metrics of ED LOS, LWBS rate, ED Consult Response Time from the four months prior to intervention (March-June 2014) to the four months following intervention (July-October 2014). For patients admitted to medicine service, the ED median LOS was reduced from 428min to 354min (74min absolute change, 17% relative reduction, $p<0.005$). A majority of this decrease was attributed to a reduction in the median ED Consult Response Time from 147min to 80min (67min absolute change, 46% relative reduction) due to the three interventions. Ultimately, ED LWBS rate fell from 6.1% to 3.4% (2.7% absolute change, 44% relative reduction).

**Conclusions:** Improvement in ED LOS for medicine patients can be successfully addressed with straightforward interventions that are possible in most hospitals. We focused on a transition orderset for a select group of stable patients to be admitted quickly, incorporation of the admission decision metric in hospitalist's yearly quality financial incentive plans, and consistent education of the importance of these metrics to hospitalists, ED physicians, and nursing.