ED to ED Inter-facility Transfer for Injured Patients

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Background/Purpose:
Direct Admission (DA) rates were identified as a weakness during our Level I trauma review. Evidence suggests decline in mortality for patients (pts) transferred from a nontertiary or nondesignated trauma center to a Level I trauma center. Given risks related to transferring injured pts, a 2nd Emergency Department (ED) stop allows re-evaluation to identify physiologic derangement, under-triage and under-resuscitation.
Specific aims of this performance improvement project were to
1) identify inter-facility transfer issues leading to DA and
2) develop process to streamline inter-facility transfers.

Project Design:
Data collected 1/2017 – 2/2018 prior to implementation and 8/2018 – 9/2018 post implementation.

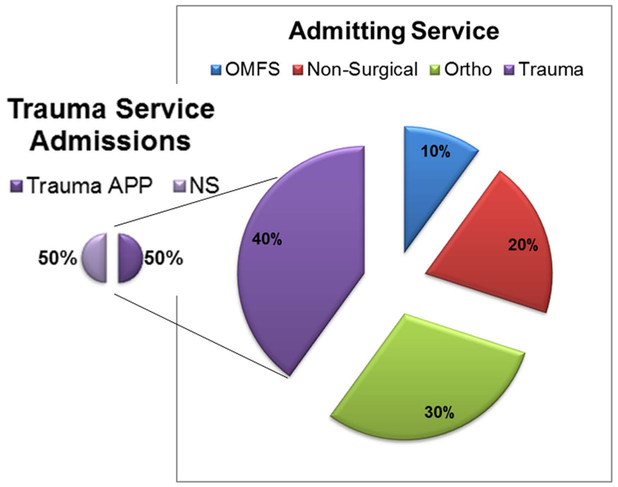
Setting:
Level 1 community hospital.

Sample:
Level 1 trauma center registry sample of 30 injured patients, age 14 and older.

Procedures:
Retrospective review examined DA data from 1/2017 – 2/2018. DAs were defined as patients admitted directly to inpatient from referring facility ED. Inpatient to inpatient admissions were \ excluded. Thirty DAs were identified during the study period then data was collected on the following variables using descriptive statistics:

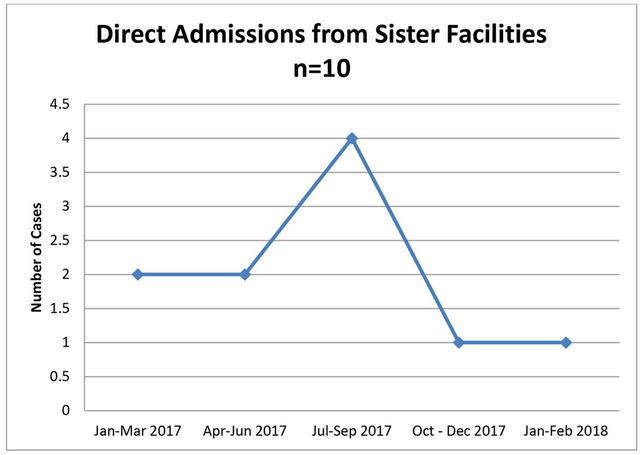
- Volume of DAs by month
- Transferring facility
- Admitting service
- Trauma surgeon consultation (yes/no)
- Number of patients admitted with multiple versus single system injury
- Number of DAs admitted to trauma service arranged by an advanced practice provider and consulting service

Prospective review examined DA occurrences post performance improvement project implementation from 8/2018 – 9/2018.



Injured patient interfacility transfer into Memorial Hospital Central (MHC) from a sister facility (e.g. Memorial Hospital North and Free Standing Emergency Departments (FSEDs)).

*Current proposal, referring MD has to make 2 phone calls and wait on the phone. This can be time consuming on both ends. Planning a scripting option *(i.e. DL give option (during 1st call) to allow referring ED MD to directly call accepting ED MD*



Results
The findings over a 14 month period included:

- 30 total DAs
- 33% (10/30) came from sister facilities

Sister facilities:
- 100% (10/10) single system injuries (isolated extremity fracture, facial trauma, etc.)
- 60% (6/10) trauma surgeon was not involved in the care
- Remaining 40% (4/10) were arranged by trauma advance practice provider or neurosurgeon

Discussion
Trauma Services collaborated with ED to map ED to ED transfer process. The group identified barriers and addressed accordingly.

- Barrier: Injured patients not being identified as trauma patients.
  Solution: Group communally defined target population.
- Barrier: Varying transfer processes for different patient populations.
  Solution: Implemented uniform transfer process for every patient.
- Barrier: ED MD makes numerous calls to arrange transfer and consults.
  Solution: ED MD makes one call to DocLine (referral center).
- Barrier: Other service-lines (orthopedic surgery; neurosurgery; nonsurgical) accepting injured patient transfers.
  Solution: Trauma surgeon receives the call and accepts all injured patients transfers.

The team partnered with the DocLine and solutions were imbedded into the algorithm. The DocLine Interfacility Transfer flow chart was then vetted through appropriate stakeholders and the process was successfully beta-tested in August 2018.

Next Steps
Future development of the project will continue with data collection, monitoring transfers and continuing to identify opportunities for improvement with the goal of reducing DAs by 10% in FY 2019.

References
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