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12

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Hardwire Flow in the Emergency Department

By Stephanie J. Baker, RN, CEN, MBA
Kirk Jensen, MD, MBA, FACEP
and Thom Mayer MD, FACEP, FAAP

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How can we deal with ED overcrowding, boarders, and long wait times?



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MESSAGE FROM QUINT

IMPROVE FLOW FOR HIGHER PATIENT SATISFACTION, LOYALTY, AND GROWTH.



HEALTHCARE FLYWHEEL®

Recently, I was reviewing emergency department data for a number of our client partner hospitals that showed a clear correlation: As ED patient satisfaction rises, so does inpatient satisfaction. As Stephanie Baker, Dr. Jensen and Dr. Mayer explain in our cover story, “Hardwiring Flow in the Emergency Department,” the ED in an average hospital accounts for 50 percent of admissions.

It makes sense then that to grow patient satisfaction, loyalty, and volumes hospitalwide, it’s critical to make a strong first impression with patients in the ED. But that can be challenging, right? The pressures on EDs are worse than ever, with overcrowding at the top of the list!

That’s why we’ve dedicated this issue of *Hardwired Results* to practical tools, tips, and tactics that improve flow in the ED while also increasing patient satisfaction, building growth, and delivering strong return on investment in real, green dollars.

For example, you’ll read about how hourly rounding on patients moved one ED from the 6th percentile to the 99th while creating a \$1.6 million positive financial impact. You’ll get tips from experts on making effective post-visit phone calls to create highly loyal patients. And you’ll find out how “AIDET” can reduce Left Without Seen patients dramatically to recoup otherwise lost revenue. Plus, CEOs share top tips on how to improve performance in the ED. Experienced nurse leaders offer time-tested techniques on how to remove barriers to excellence.

If these case studies pique your interest, I’d encourage you to attend Studer Group’s two-day institute “The Nuts and Bolts of Operational Excellence in the Emergency Department,” May 5 to 6 in Richardson, TX. That’s how many of these leaders got started. (I would also encourage you to take advantage of our ED assessment. See page 11 for details.)

Yours in service,

Quint Studer

CEO, Studer Group
Quint@studergroup.com



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Hardwiring Flow in the Emergency Department

By Stephanie J. Baker, RN, CEN, MBA, Kirk Jensen, MD, MBA, FACEP, and Thom Mayer MD, FACEP, FAAP

It's a fact: The emergency department is the major point of entry for the largest number of patients arriving to your hospital. Typically, the ED accounts for 50 percent of inpatient admissions, 75 percent of plain radiographs, and 50 percent of CT scans and ultrasounds in the entire hospital. Plus, as the "front door" to the hospital, the ED not only drives flow, but it drives the patient's *perception* of flow.



Download a blank reception area rounding log.

Log on to studergroup.com/excellenceintheed/rarl

To ensure efficient emergency department patient flow, begin to think of the ED as a system with inputs, throughputs, and outputs. The inputs are patients coming into the ED, either by ambulance (typically 25 percent of patients) or through triage (75 percent of patients). The outputs are discharged patients (or those admitted to the hospital or transferred to another hospital.) And while it

Here are six more ways to improve front-end flow:

1. **Measure patient demand by hour**, so you can match staffing and ancillary services to handle it;
2. **Manage triage effectively so there is no bottleneck.** Remember, triage is a process, not a place. Its function is to evaluate and expedite—not to delay—patient care. (You'll also

“Emergency department patient flow is like a rope: It works great when you pull, but pushing doesn't get you far.”

might seem that the best place to start testing changes is to focus on throughputs (e.g. wait times for lab and radiology), the biggest opportunities to affect patient flow are actually at the front end and back end of the ED.

Six Strategies to Improve Flow on the Front End

The front end is where the ED team has the most direct control and influence over patient flow, resources, and service. Begin by understanding the demand for ED services by hour of the day and day of the week and your corresponding capacity to deliver. After all, even though your patients didn't know they'd be visiting your ED today, you knew they'd be arriving, didn't you? You may not have known their names, but if you measure, analyze, and track trends, you can plan processes to accurately anticipate their needs.

Emergency department patient flow is like a rope: It works great when you pull, but pushing doesn't get you far. To improve flow, coordinated teamwork should “pull” patients through by anticipating where patients come from and go next, rather than attempting to “push” them through by looking for available beds or waiting for the admitting physician to see the patient and write orders.

want to segment patients so that vertical patients stay vertical and moving. Remember, the most valuable member of the ED team in many emergency departments is the gurney or bed! Flow depends on optimizing bed turns.)

3. **Design and deploy a “fast track” approach** to move easy-to-treat patients—who require few resources—through the system efficiently. (Fast track is a verb, not a noun.)
4. **Get the staffing and the team right.** Let doctors do “doctor stuff” and nurses do “nurse stuff.” If patients are waiting for physicians or nurses, streamline processes and ensure that members of your team are only doing tasks they are uniquely qualified to do.
5. **Establish a results waiting area.** The goal: a visible space near triage and fast track where patients can wait for radiology and lab results without using ED beds. Make customer service a top priority here.
6. **Track patients and results.** Use a good patient flow dashboard to monitor patient care in “real time” cycles so everyone on the team can see when, where, and why ED operations and services start backing up to react quickly.

Round Hourly in the Reception Area

Once you have implemented several of the above strategies to improve flow on the front end, you can focus on improving the waiting experience. When you round hourly on patients and families in the reception area, you will reduce the number of patients who leave without being seen. This has both a patient safety and a financial impact.

The average ED loses at least two percent of patients—and revenue—when patients are unwilling to wait. **If we can keep just two to three extra billable patients each day for a year, that adds an additional \$219,000 to \$328,500 to your organization's bottom line** (assuming an average reimbursement rate of \$300 per treat and release ED patient).

Goals for rounding in the reception area: Show care and concern for the patient. Keep them informed about delays. Reassess the patient's status. And improve patient satisfaction. Who rounds? While the triage nurse owns the process, EDs that Studer Group coaches use charge nurses, registration clerks, security, chaplains, case managers, ancillary staff, and even senior leaders to help round in the reception area. It's a team sport!

A final tip on rounding: Keep a 24-hour reception area rounding log. By asking staff to initial and comment (e.g. 1 pm: "25 people waiting"), the manager can review the log for trends, compliance with rounding, any need for real-time adjustments, and communicate effectively back to staff.

"Triage is a process, not a place. "Fast Track" is a verb, not a noun."

Improve Back End Flow

If the boarding burden in your ED is a real but infrequent problem, a great deal can be accomplished with the critical flow concepts discussed above. However, if one-third to one-

half of your ED beds are tied up with boarders on a regular basis, your flow efforts will, in our experience, be met with minimal and only temporary success.

continued on page 4

▼ 12 Critical ED Patient Flow Concepts	
1	The front door and your front end processes drive flow.
2	Triage is a process, not a place.
3	Get the patient and the doctor together as quickly and efficiently as possible.
4	"Fast track" is a verb, not a noun.
5	Keep your vertical patients vertical and in motion.
6	Patients who need few or limited resources should not routinely wait behind those patients who need multiple resources—regardless of how heavy the ED patient volume is.
7	For horizontal patients, real estate matters. For vertical patients, speed matters.
8	We want to be fast at fast things and slow at slow things.
9	Flow occurs when doctors do "doctor stuff" and nurses do "nurse stuff."
10	Good IT won't fix bad processes—and mediocre IT makes things even worse.
11	Making people unhappy and then sending them a bill is not a healthy business model.
12	Satisfaction does matter—for you, for your team, and your patients.

In this case, your team's efforts will best be leveraged by attacking and solving the boarder issue first. Take these three steps:

1. Define the magnitude of the problem. Collect data on ED length of stay for admitted patients and data on total ED boarding hours or other delays in the care of admitted patients.

2. Flow chart the admission process. Gather a team of four to eight people who are intimately familiar with the admission process from your department (e.g. a physician, nurse, a ward clerk and admission personnel). Flow chart the process using markers and Post-Its and then agree on ways to simplify processes and reduce wasted steps or activities.

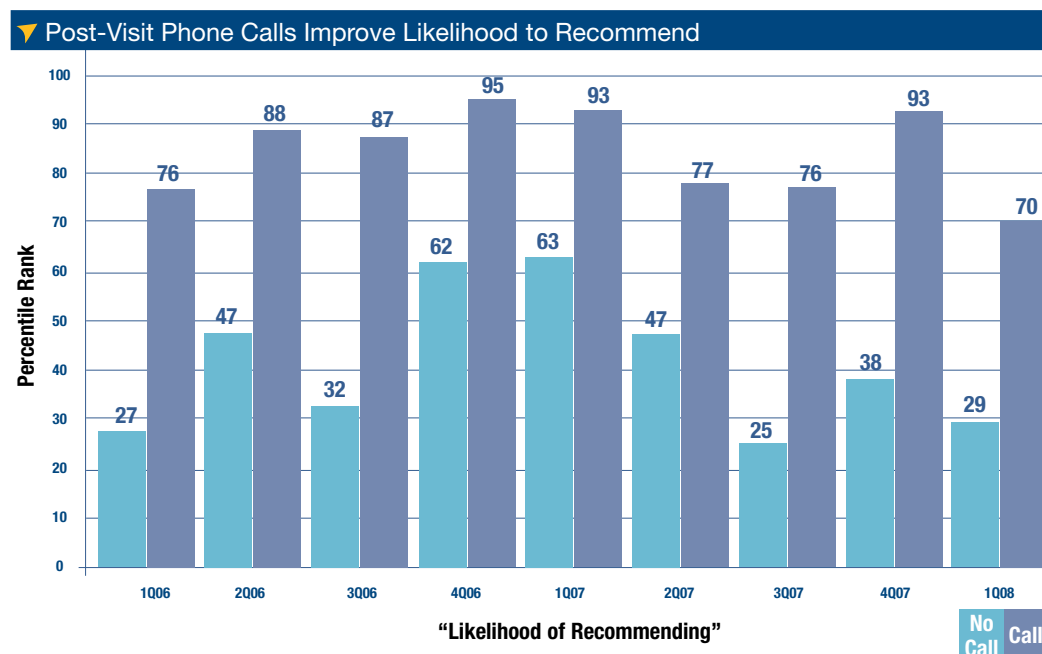
3. Collect data on delays. Monitor data for a month or two. Then identify the top three reasons for admissions delays so you can take action. (One ED we worked with that did this kind of analysis learned that 80% of their delays were because nurses did not have admission orders or a clean bed...not because they were "too busy" to take an admission as ED personnel suspected!)

Other Considerations When Discharging Patients

To maximize patient flow on the back-end, aim for a goal of 15 minutes or less from discharge order to "out the door." The goal, of course, is to ensure that once the discharge order is written, staff can expedite the discharge quickly.

Here are some additional discharge practices that have proven effective in some EDs. However, it is necessary to assess process and resources to determine feasibility and maintain quality:

- Asking physicians to provide all discharge instructions to the patient, including a patient signature on all discharge papers at this "formal close." This saves time because the nurse does not need to reiterate instructions. (However, physicians must provide the patient chart to the nurse post-discharge to close out the visit.)
- Larger EDs (50,000 patient volume or greater) may use a discharge lounge



Hackensack University Medical Center, in Hackensack, NJ, tested the impact of post-visit phone calls on ED patients by comparing those who received a call to those who did not. Consistently, those who received the call were far more likely to recommend the ED than those who did not receive a call.

Hackensack University Medical Center, in Hackensack, NJ. 2008 ED visits: 74,832. Total Beds: 775

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By Stephanie Baker, RN, MBA, CEN

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or waiting area or use provider-assisted discharges.

- Other large EDs assign a “discharge nurse” during peak times who focuses specifically on anticipating and expediting discharges.

Once a patient has been discharged from the ED, ask physicians and nurses to make a follow-up phone call within 72 hours using a standardized template for questions to ask. Post-visit phone calls improve clinical outcomes, increase patient satisfaction, and decrease costly and unnecessary return visits to the ED as well as avoidable re-admissions to the hospital. (In one study of 400 patients, almost one in five patients reported an adverse event post-discharge. Forty-eight percent of those events were preventable!)

The long-term best practice goal is to attempt to call 100 percent of eligible patients discharged to home, reaching 60 percent of

patients within 72 hours after discharge.

Organizations using this goal typically see initial results in 60 to 90 days with higher patient satisfaction, fewer re-admits due to increased understanding of discharge instructions, fewer patient complaints, and greater patient loyalty and market share. EDs begin to get results once they attain at least a 60 percent contact rate.

In conclusion, expediting flow is critical to improving the patient experience in your ED. Remember, the primary goals of ED patients are to see a physician quickly, get the right diagnosis/right treatment, and be kept informed about their plan of care (and what they are waiting on). Patients want to have a clear understanding of their diagnosis, how to treat it, and what to do when they leave. When you improve flow, you serve more patients with less effort, and you serve them better!

Leader and Hourly Rounding Drive Gains from the 6th to 99th Percentile

with ED Medical Director Dr. Paul Andrulonis and ED director Donna Sparks at Baptist Miami Hospital, Miami, FL

“Back in 2006, our patient satisfaction was chronically in the single digits and our Left Without Being Seen rate was in the double digits,” explains Donna Sparks, Director of the Emergency Department at Baptist Miami Hospital in Miami, FL (80,000 annual adult ED visits). Since then, the ED team has created a patient-centric environment that has increased patient satisfaction from the sixth to the 99th percentile nationwide.



Baptist Miami Gains \$1.6 million

In the last two years, Baptist Miami’s ED reduced LWOBS patients by four percent for revenue gains of \$1.6 million by using hourly rounding so patients were more willing to wait.

Learn more about hourly rounding in the ED by logging on to: www.studergroup.com/ED_study to read about Studer Group’s study of hourly rounding in the ED.

Get details on how to use the four rounding tools used in the study at www.studergroup.com/hourly_rounding_tools

Other key outcomes: Since 2006, the number of patients who leave against medical advice has dropped three percent. The ED also reduced Left Without Being Seen patients from 7.5 to 3.06 percent—a \$1.6 million positive financial impact in just the last year alone.¹

The Tools that Changed the Culture

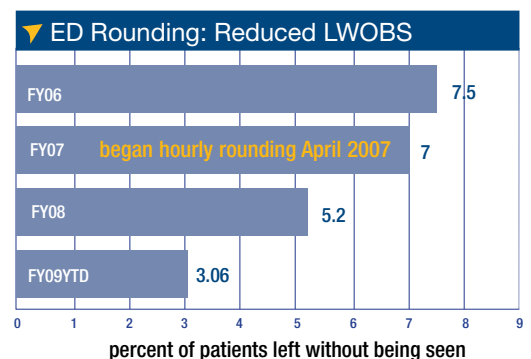
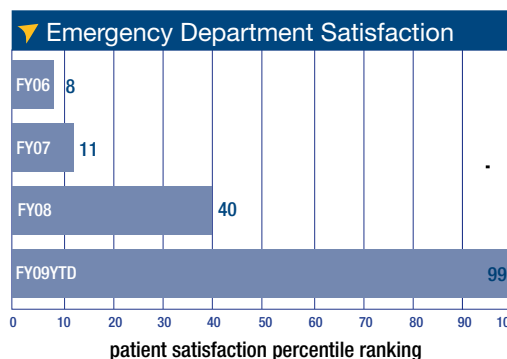
Sparks credits many of the results to the ED’s ability to hardwire leader rounding on patients and hourly rounding on patients by staff. “We rounded on patients in the presence of staff. They could hear us ask patients if staff were rounding on them,” explains Sparks. “That validated the importance of the behaviors and drove a culture change. We were relentlessly diligent even when we didn’t see our numbers come up. The pay-off came over time.”

While Sparks rolled out hourly rounding to ED nurses, Dr. Paul Andrulonis, Baptist Miami’s ED Medical Director, focused on

educating the medical staff. “We had lots of challenges,” Dr. Andrulonis explains. “We moved from a mid-level physician model to an all physician model, for one thing. We also faced lots of initial push-back from both physicians and nurses.”

What helped the most? “Tying these practices to evidence in the literature (e.g. rounding on patients reduces falls and call lights),” he adds. “We also showed physicians what was in it for them...how it would benefit their practice by reducing malpractice claims and improve clinical decision-making by gaining more information at the bedside.”

“I remember our Aha! moment,” adds Sparks. “We had a pizza party when we finally hit the double digits in patient satisfaction. Staff saw that they could make a big difference for patients...even before we expanded our ED and we had lots of infrastructure challenges. Even patients who were cramped in the hallways appreciated their efforts.”



Baptist Miami raised patient satisfaction from the 6th to 99th percentile over four years while reducing Left Without Being Seen patients from 7.5 to 3.06 percent. Since implementing hourly rounding in 2007, the ED has realized a return on investment of \$1,558,400 by retaining an additional 3,200 patients.

¹ \$1,558,400 financial impact is based on average net revenue of \$487 per LWOBS patients retained. Reducing LWOBS 4% in FY07 to 09 on ED adult visits of 80,000 yields an additional 3,200 patients.

AIDET Builds Patient Loyalty and Volumes

with CNO Kate Cronin, ED Medical Director Dr. Harnet Sethi, and Nursing Director Cheryl Pinney, Cheshire Medical Center/Dartmouth-Hitchcock Keene Emergency Department, Keene, NH

In early 2005, Cheshire Medical Center/Dartmouth-Hitchcock Keene Emergency Department (an ED with 28,400 annual visits in Keene, NH) was ranked in the 10th percentile for patient satisfaction with almost three percent of ED patients leaving without being seen (LWOBS).

Fast forward to December 2009: patient visits are up 31 percent since those days, while LWOBS has dropped to 1.3 percent. Since the ED introduced AIDET, bedside report, and nurse leader rounding, in 2007, a surge in new patients has resulted in more than \$2 million in additional revenue². Patient satisfaction has skyrocketed to the 94th percentile as measured by the competitive New England Peer Group and 96th percent nationwide. And in spite of this large increase in patient volumes, the ED kept door-to-doc time stable, at an impressive average of just 41 minutes, and a stable turn around time of 181 minutes for treat and release patients with no increase in staff or beds! How'd they do it?

AIDET Gets Results

The ED created a patient-centric model that created strong word of mouth and loyalty in the community. One key tool in effecting the change was the use of Studer Group's Five Fundamentals of Service, otherwise known as "AIDET", which stands for Acknowledge—Introduce—Duration—Explanation—Thank You.

"AIDET are powerful key words we can use to improve patient perception and experience," explains the ED's Studer Group Coach Julie Kennedy-Oehlert, RN. "AIDET reduces LWOBS because patients who are informed about the wait are more likely to stay and receive the treatment they need. And it reduces patient anxiety while creating a relationship with patients that can improve their compliance with plan of care."

"Initially, the ED team began by acknowledging the patient and introducing themselves, but staff were uncomfortable about giving a duration for tests and procedures in case we made promises we couldn't keep," explains CNO Kate Cronin. "But we were

surprised. By giving wait times and updating patients when and why it took longer, we got great feedback which motivated us and created a positive cycle of change."

Since the ED knows that it will typically hold chest pain patients for six hours, for example, staff can let patients know ahead of time and use key words to connect to why (e.g., "It's important to stay to ensure your health is not in danger.") Now patients will stay while a friend or spouse runs an errand or lets the dog out.

"What's most valuable about AIDET is that it provides a concrete framework for high quality patient interactions," explains Dr. Harnet Sethi, ED Medical Director. "We can train staff in these competencies specifically instead of just telling them to 'be nicer.'"

Another hurdle the ED overcame: "Initially, staff didn't want to move their badge to shoulder height," explains ED Nursing Director Cheryl Pinney. "Registrars asked why patients needed to know their names. But it quickly became apparent to all of us that patients felt more valued...especially when we asked the names of visitors and family members. Suddenly, staff weren't hiding behind nurses anymore."

The ED team at Cheshire Medical Center/Dartmouth-Hitchcock admits that hardwiring takes rigorous accountability. "Shadow staff so they see you do it," recommends Pinney. "And follow up with patients to validate it's happening. When you say, 'Mr. Jones in bed 11 has no idea what your name is. Did you use AIDET?', staff understand it's a priority."

Cheryl Pinney's top tip? "Don't give up! This requires persistence and true buy-in from leaders, particularly physicians. It can't be something that only nurses and registration staff do in the ED. We regroup and refocus after a bad shift. Every patient gives us another opportunity to get it right."



Cheshire Medical Center Builds Volumes

Through the use of AIDET, bedside report, and nurse leader rounding, Cheshire Medical Center/Dartmouth-Hitchcock Keene Emergency Department has built patient loyalty for higher volumes of more than \$2 million in new revenue.

² \$2,036,100 new revenue is based on an additional 6,787 patients over three years at an average treat and release rate of \$300.

7 Tips for Post-Visit Phone Calls that Get Results

with COO Art Gladstone, ED Medical Director Dr. William Lee, and ED Nursing Director Sally Kamai at Straub Clinic and Hospital, Honolulu, Hawaii

Effective post-visit phone calls provide an opportunity to check clinical quality, harvest reward and recognition, and identify trends or areas of improvement through first-hand feedback from patients.

“Post-visit phone calls create valuable patient loyalty because they are closely correlated with a patient’s likelihood to recommend,” explains Straub’s Studer Group Coach Julie Kennedy-Oehlert, RN. (In “The One Number You Need to Grow,” *Harvard Business Review*, December 2003, the authors find that “likelihood to recommend” is the best predictor of organizational growth, across all industries.)

The ED team at Straub Clinic and Hospital, Honolulu, Hawaii (one of four medical affiliates with Hawaii-Pacific Health System) has increased ED patient satisfaction from the 77th to 99th percentile in the past 12 months, primarily by hardwiring post-visit phone calls to their discharged patients and their families. The ED has a volume of 21,000 patients annually.

Here are some tips from the team:

1. Get organized. “In the beginning staff were reluctant to make the calls and fearful of hearing complaints,” explains ED Nursing Manager Raylene Nolan. “We’d find call back papers all over the place when they got busy.” But by computerizing a call log and encouraging some friendly competition, staff got on board and heard mostly good news. One nurse has already made 5,000 calls!

2. Make calls within 72 hours post-discharge. A recent article in the *Annals of Emergency Medicine*³ found that 78 percent of ED patients do not understand at least one area—and 50 percent do understand two or more areas—of their care plan, diagnosis, treatment, instructions for home care, and warning signs of when to return to the hospital.

In fact, Dr. Lee, the ED medical director, notes that many patients were confused about follow-up care and medications. Today at Straub, the number of patients who rate the ED as “very good” on information about home care has moved up from 58 percent to 71 percent. Doctors keeping patients informed about their treatments at Straub is ranked at the 98th percentile in a national database.

3. Follow up on trends and opportunities. Through the calls, staff learned that many patients had trouble getting access to primary care physicians for follow-up appointments. Now the ED schedules the appointments before patients leave. This practice assists patients who have been seen in the ED to obtain the appropriate level of follow-up care instead of returning to the ED, and improves access for patients who really need emergency care.

4. Engage your middle performers. “When fence-sitters in the ED saw high performers really getting into the fun competition of making the calls, they got engaged,” notes COO Art Gladstone. “Post-visit phone calls are an excellent mechanism for moving performance.”

5. Ensure accountability and transparency. At Straub, the goal is to contact 100 percent of eligible discharged patients within 24 hours. Straub believes that every patient deserves follow-up care through a post-visit call. Result? The ED is ranked in the 99th percentile for “cares about me as a person” on patient satisfaction surveys. Leaders track accountability for making the calls by users, to reward and recognize those who reach patients.

6. Make it easy. “It’s helpful to have one person launch it,” suggests Gladstone. “And make the process easy,” adds Dr. Lee. “Straub uses automated software that each staff and physician can access for patient names and contact information. By asking the nurse or physician who took care of the patient to look at a screen with a list of patients, you take away the barrier of complexity.”

7. Manage Up! “Nurses might have certain perceptions about their colleagues that change when the patient tells them what wonderful care they received,” explains ED Nursing Director Sally Kamai. “We ask everyone who makes calls to pass on those compliments to the manager or charge nurse so they can be recognized for living our values.” “The more calls you make, the less fearful you are,” Nolan adds. “You get a thank you after every call. It’s a great part of the day!”



Get the tools you need

Download a sample post-visit phone call template and trend report at www.studergroup.com/excellenceinthead_calls

³ *Annals of Emergency Medicine*, “Patient Comprehension of Emergency Department Care and Instructions: Are Patients Aware of When They Do Not Understand?” 53 (4): 454-461.

Top Tips from CEOs for Improving ED Performance

Wondering how senior leaders can effectively drive change in the ED? Here, Rick Lassiter, CAO at Parkwest Medical Center in Knoxville, TN and Janet Wagner, CEO at Sutter Davis Hospital in Davis, CA share their perspectives.

HR: Why is ED flow so important?

RL: The ED is the front door to your organization and your community. Forty percent of our admissions come from the ED. With high volumes, reducing long turnaround times is key. In fact, when I'm at church or in the grocery store and I see patients, that's one of the first things they mention: a long wait time! In the ED, we work on getting patients who need to be seen out the door faster. On the inpatient side, we work on getting those who need to be admitted into a bed sooner.

HR: How can CEOs play an effective role in addressing ED flow challenges?

JW: Stay engaged with staff and physicians. I make high patient satisfaction a priority. We measure by shift and department in the ED. CEOs can verbalize the expectation and support staff with education and training. The ED is important for CEOs to stay close to because it is very often the first experience the patient has with the hospital and influences the remainder of the stay.

RL: Make it a part of what you talk about every day. I attended frequent meetings of our Flow Team along with the CNO and CFO to raise visibility of this issue. We asked tough questions, like "How long does it take to clean a bed? What's the turnaround time for housekeeping?" By identifying barriers as a team, we identified seven flow obstacles to overcome and raised accountability.

The end result was the development of an electronic Flow Board that's posted on every unit so we can see what patients are waiting on. The goal: Discharge 40 percent of patients by 11 am (instead of seven percent). After nine months, our pilot unit is meeting goal, with the rest of the hospital at 13 to 14 percent.

HR: How do you use accountability to support and drive change?

JW: For patient satisfaction, we have weekly meetings with managers and post results on all units once a week. If satisfaction drops, I

ask staff to focus on a strategy for recovery. It's a coach-support-train model for sustaining results. This creates the infrastructure so everyone knows how to read the patient satisfaction surveys and use the data.

RL: We use Studer Group's Leader Evaluation Manager™. Every nursing manager has a heavily weighted goal on his or her evaluation to discharge 40 percent of patients by 11 am.

HR: Has improved flow in the ED contributed to higher satisfaction by the medical staff?

RL: Our medical staff is mainly concerned that their post-op or direct admission patients are placed in a room in a timely, efficient fashion. Since they essentially compete for beds with ED admissions, we changed our process by discharging patients earlier in the day. By reviewing the surgery schedule and relying on our ED admission trend data, a flow coordinator can plan for anticipated admits from post-op early in the day and ED admits for later.

Our admissions are up five percent over last year; surgery minutes are up 11 percent and ED visits are up 3.5 percent. Yet, length of stay is fairly constant. Our work on flow has helped us handle the volumes.

HR: Any advice to other senior leaders looking to improve flow in the ED?

JW: Look at the process and engage physicians and staff to improve cycle times where needed. Ensure someone is managing those processes every day and every shift. It's like air traffic control. And absolutely include key physicians, medical staff and the hospitalist. You need physicians who understand and can respond to flow challenges as well as managers who can execute improvements.

And remember, just because we improve something, doesn't mean it's easy to sustain it! Process improvement is an ongoing endeavor. It requires a culture and mindset of constant attention.



View Parkwest's Flow Board

Download a sample flow board at studer.com/flowboard



Rick Lassiter is president and chief administrative officer of Parkwest Medical Center, a 462 bed hospital in Knoxville TN, affiliated with Covenant Health with 45,000 ED visits annually. Patient satisfaction in the ED over the past 12 months has been in the 82nd percentile.



Janet Wagner is CEO of Sutter Davis Hospital, a 48 bed hospital in Davis, CA affiliated with Sutter Health with 21,526 ED visits annually. Patient satisfaction in the ED over the past 12 months is in the 85th percentile.

Use Super Track

with CNO Janice McKinley and ED Director Darrell Brackett, Parkwest Medical Center, Knoxville, TN

With new minute clinics popping up all over, Parkwest Medical Center (with 45,000 ED visits annually) in Knoxville, TN saw a general rise in the acuity of its ED patients as lower acuity patients were siphoned off. Newly motivated to address length of stay issues with that market segment, the ED resolved to serve them faster. The result? A 50 percent reduction in Left Without Being Seen patients for an additional \$230,000 in annualized revenue over the three month pilot in Q4 2009. (A sidenote: Since 1996 when the Parkwest ED won the “Toilet Bowl” award for being in the 5th percentile for patient satisfaction, it’s raised it to all the way to the 82nd percentile.)

SELF-TEST ANSWERS:

continued from back cover

HOW DID YOU RATE?

If you answered “yes”:



8 or more times:

Congratulations. You’ve hardwired flow in the emergency department. Maintain your advantage and stretch your skills by attending Studer Group’s 2010 What’s Right in Healthcare Conference October 18 to 20 in Dallas, TX.

6 to 7 times:

Your organization is well on its way to hardwiring excellence in the ED. Here’s how to take it to the next level with resources at www.studergroup.com:

- Register now for Studer Group’s two-day Institute **Nuts and Bolts of Operational Excellence in the Emergency Department**, May 5 to 6, Richardson, Texas.
- Request an ED assessment. Call Marcie Rohleder at (972) 860-0552.
- Read *Excellence in the Emergency Department: How to Get Results* by Stephanie Baker, RN
- Read *Hardwiring Flow: Systems and Processes for Seamless Patient Care* by Thom Mayer, MD and Kirk Jensen, MD.

5 or less times:

If you are reading this issue of *Hardwired Results* and have completed this self-test, you’ve already demonstrated your commitment to improving flow in the ED.

Take the next step today at www.studergroup.com to read *Hardwiring Excellence* by Quint Studer

Getting Started with Super Track

First, ED leaders attended a weeklong training session on lean management techniques sponsored by the University of Tennessee last summer. Then they applied the tools they learned to the length of stay challenge. The goal: Drop door to doc time by 15 percent and reduce length of stay in the Super Track to 50 minutes or less.

The process: A staff team used a lean design method to design a new “Super Track” process to see level 4 and 5 minor acuity patients. To qualify for Super Track, patients must meet specific criteria. Those who do not need

trials and refinements, an industrial engineer would measure and re-measure so the team could visually see the time impact of various approaches. Using immediate bedding to skip wasted time in triage was one innovation that came out of the team’s measurement activities.

Identify and Overcome Barriers

The team also identified barriers to hardwiring the process and solutions to overcome them. When it became clear, for example, that the night shift wasn’t receiving the same communication as the day shift, they hardwired night shift training by sending a day staff person to keep them current. Also, in the begin-

“Now that we’ve learned how to work through a complex process using lean tools, we’re going to tackle other flow issues like diagnosis to discharge.”

ning, the staff noticed tremendous variation based on which staff were working. By engaging high performers to train others, everyone excelled.

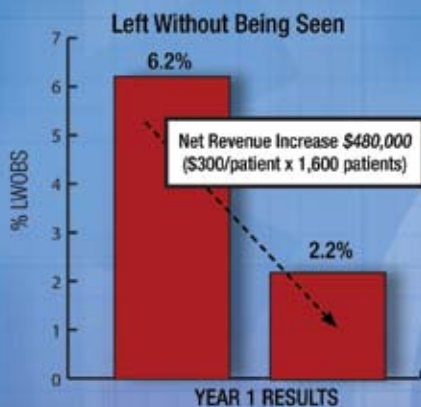
labwork, have minor injuries or simple x-rays for ankle injuries, for example, are included. Super Track patients skip triage and are instead greeted by a CNA or nurse practitioner for a quick assessment and immediate bedding. Patients then go through a parallel assessment with a physician and nurse. Afterwards they are discharged or go to x-ray.

Keys to Hardwiring the Process

Meet and measure. In the beginning, a team of high-performing nurses and technicians met weekly to identify which processes were value-added and which were not, to make a dramatic impact in a quick amount of time. Based on their

Track performance. The ED team also uses a monthly dashboard to track daily performance to goal on LWOBS patients, average length of stay, and total ED patients. Updated weekly and posted monthly, the dashboard kept staff tracking to target. This transparency also helped staff understand the effect of mid-course corrections to the Super Track process. “Reviewing results at a daily staff huddle really helped hardwire results and make early course corrections,” explains Parkwest’s Studer Group Coach Stephanie Baker, RN.

**IMPROVE OPERATIONS, PATIENT FLOW, & REPUTATION
within 12-18 months
with Specialized Emergency Department Coaching**



- ▶ Decrease "left without treatment" rates
- ▶ Increase upfront collections
- ▶ Improve hospital and physician revenue
- ▶ Reduce door-to-doctor time
- ▶ Increase patient satisfaction
- ▶ Decrease employee turnover

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Source: Texas Hospital ED visits: 40,000

For more information on Studer Group Emergency Department Coaching or an ED assessment, please call Marcie Rohleder at (972) 860-0552 or visit www.studergroup.com/EDexcellence

"Now that we've learned how to work through a complex process using lean tools, we're going to tackle other flow issues like diagnosis to discharge," explains ED Director Darrell Brackett. "The Super Track model will be used as best practice for the rest of the hospital."

The Results

Even though Super Track was implemented during the ED's H1N1 census peak, patient satisfaction remained high and stable because of the newly gained operational efficiency. By December 2009, ALOS was well below the 50 minute goal at 39 minutes—beating the 50 minute goal 30 out of 31 days—and

LWOBS had dropped from 3% to 1.6%. What do patients think? Parkwest consistently hears that patients love it through comments on its website and through post-visit phone calls.

A Final Tip

"Set clear expectations and follow through by continually reviewing data," suggests CNO Janice McKinley. "Also, expect some false starts, but keep going!"



Parkwest Medical Center ED Reduces LWOBS Patients

The ED's new Super Track dramatically cuts wait times for a 50 percent reduction in LWOBS for increased annualized revenue of \$230,000 in the first three months of the roll out.



Institute Calendar

Register now at www.studergroup.com. Contact Sheila Martin at 850-343-0212 to learn how you can bring an Institute or speaker on-site.

What's Right in Health Care 2010 Conference

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April 21 to 22
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Nuts and Bolts of Operational Excellence in the Emergency Department

May 5 to May 6
Richardson, TX

Nurse Leader Q&A: Overcoming Barriers to Excellence in the ED

Learn from the experts. Kate Cronin, MS, RN CNO at Cheshire Medical Center/Dartmouth-Hitchcock Keene in Keene, NH and Donna Sparks, MSN, RN Director, Emergency Services at Baptist Miami Hospital, Miami FL tell you what it takes to excel in the ED.



Kate Cronin, MS, RN is Senior Vice President of Patient Care Services and Chief Nurse Officer at Cheshire Medical Center/Dartmouth-Hitchcock Keene in Keene, NH with 28,000 ED visits annually. The medical center's ED is ranked in the 94th percentile of the ultra-competitive New England Peer Group for overall patient satisfaction and in the 96th percentile for all EDs nationwide.



Donna Sparks, MSN, RN, NEABC, CEN is Director, Emergency Services (70,000 visits annually) at Baptist Hospital of Miami, Miami FL, where she has watched patient satisfaction in the ED rise from the sixth percentile to the 99th percentile since January 2007. "It's a success story beyond my wildest dreams!" says Donna.

HR: What barriers did you have to remove to create a culture of excellence in the ED?

KC: Like in other EDs, our culture was a major barrier. We felt it was our job to save lives...not to do these "other" things. We also believed our patients were different from those in other EDs (e.g., more psych patients, sicker patients, less willing to complete patient satisfaction surveys). Plus we thought, "Hey, we're already pretty good compared to the other EDs in town. Patients don't usually have to wait more than four to five hours to be seen, so what's the problem?"

DS: I didn't see the challenge so much as "barriers", but the need to find ways to demonstrate "what's in it for me" to staff. When we started hourly rounding in the ED, we shared evidence from the literature that showed why this was an evidence-based nursing practice to provide better patient care and how it would reduce call lights by anticipating patient needs better.

I did have one nurse who thought that completing the rounding log was a waste of time. I said, "But when you give medication, you document it, right?" I explained that we used information from the logs at our twice-a-day shift briefings to recognize staff and identify opportunities for improvement. Then he got on board.

HR: Did you find that staff resistance to change was primarily an issue of "will" or "skill?"

KC: In the beginning, it was will. The team didn't feel it was valuable or needed. This shifted once leaders in the ED owned it. Once leaders understood the data measured us against other EDs, they were determined to be better. We appealed to their competitive natures.

Later, it became a question of skill. Nurses used to avoid angry patients who had been waiting awhile. ("Don't go into cubicle 7 because they're angry!" they'd say.) But once they learned how to use AIDET, they felt comfortable defusing a patient's anger and anxiety with detailed information and genuine caring. Also, fewer complaints fueled more willingness to use the tools.

DS: Back when we started, I saw it as an issue of "will." But now that I look back, it seems like "skill". Staff didn't have the knowledge or insight about what patients were experiencing. They didn't have the training and education for rounding and AIDET. Now, we constantly re-train when we have tech turnover to ensure these behaviors remain hardwired.

HR: How did you find the time to use new tools and behaviors without adding staff?

DS: At first, triage nurses were fearful about rounding in the reception area on patients who had waited awhile. Our old ED was small and cramped then, so we'd bring blankets and pillows. But when nurses saw their managers and directors stepping up to round too, they were comforted and more confident. Patients were so receptive and complaints went down...fewer interruptions meant we got time back! Soon, it just became a better way to work that we incorporated into our routines and reinforced at shift briefings. We didn't need more staff.

HR: Do you have any advice for other nurse leaders trying to change the culture in the ED?

KC: You really need true leader buy-in—through role modeling, competency assessment, feedback, training, and holding people accountable—to succeed. If leaders do this, I think an organization can get significant results in six months. Also, provide data—share it widely and celebrate results frequently!

DS: Introduce just one or two tactics at a time to ensure they are hardwired before you layer more on. It took us a long time and a lot of effort to really hardwire hourly rounding to ensure it happened with every patient every time. At first, we used wind chimes on the loudspeaker as an audio cue. It takes time to practice a new behavior before it becomes a habit.

Cut Wait Times for Front-End Improvements in Flow...

Teamwork drives process improvement with CEO Janet Wagner, VP Medical Affairs Dr. Virginia Joyce, and Director of Nursing Tammy Needham, Sutter Davis Hospital, Davis, CA

Teamwork Drives Process Improvement

“It’s hard to introduce new policies and procedures if you don’t have solid teamwork, culture and values,” explains Janet Wagner, CEO of Sutter Davis Hospital in Davis, CA. “Our ED manager, Tammy Needham, created a culture of professionalism that provided the foundation for all our achievements in the ED.”

Those include raising ED patient satisfaction from the 36th percentile to the 89th percentile in the last two years; reducing LWOBS patients from over 3% to less than 1% and reducing use of traveling nurses from 11 to two to build a culture of ownership and high performance, and savings of 30% per position since 2007.

Collaboration Cuts Wait Times

When the ED team decided they could better serve patients and improve clinical outcomes by having ED nurses do blood draws instead of phlebotomists, they took the idea to one of their four interdisciplinary practice councils to review. The councils, which focus exclusively on improving delivery of patient care, are co-chaired by front-line staff who share decision making,

“Our goal was to meet CMS’ core measure for doing blood draws for pneumonia patients before administering antibiotics, while still giving antibiotics in a timely way,” explains Dr. Virginia Joyce, Vice President of Medical Affairs. “By allowing lab and nursing staff on the Council to work through communication issues, lab techs wouldn’t worry they’d lose their jobs if nurses did these draws.”

A monthly meeting of the ED team includes the ED manager and all physicians, who review key flow metrics that are tracked and reported out. “We focused closely on average triage to room time and reduced it from 31 to 18 minutes,” explains Needham.

“Through strong physician collaboration, we were also able to reduce average arrival to provider time from 54 to 35 minutes. The result? Fewer LWOBS patients.”

Patient Satisfaction: The Other Piece

“The other piece of flow is of course patient satisfaction,” notes Needham. “Patients don’t want to wait to be acknowledged, wait to be triaged, or wait a second time to be put in a room. By posting our patient satisfaction scores daily, we could see our performance around arriving patients – which consistently scored low.”

As a result, the ED team implemented bedside registration so patients didn’t need to wait for a room; they changed expectations for triage nurses; and worked closely with registration staff to relocate staff outside the ED to greet patients on arrival. In fact, new security cameras notified nurses at the nursing station when patients were walking up so triage nurses could proactively go to greet them. Patient satisfaction for arrivals significantly improved.

EKG capability was added to every ED room’s monitor. Each ED RN was trained to perform the procedure to reduce door to EKG time for chest pain complaint patients. “Now we can do EKG’s even in triage since we have room for a stretcher and a curtain for patient comfort and privacy”, says Needham. No more waiting for a technician with the only EKG cart to arrive.

Last thoughts? “Physician leadership in creating a culture that improves cycle time for patient throughput and patient satisfaction is crucial,” adds Wagner. “Otherwise, staff will comment that physicians are not being held accountable to the new behaviors asked of everyone else. Physicians drive a tremendous number of processes and improvements.”



Sutter Davis Gets Results

Since 2007, Sutter Davis ED has:

- raised patient satisfaction from the 36th to 89th percentile
- reduced LWOBS patients from three percent to just one percent
- reduced traveling nurses from 11 to just two, for a savings of 30 percent per position

SELF TEST

HAS YOUR EMERGENCY DEPARTMENT HARDWIRED FLOW?

Answer these questions. Then see how you rate on page 10.

1. Does your ED consistently pull until full (24/7) when beds are available?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO

6. Do you use interdisciplinary teams or forums to review ED flow challenges and implement solutions?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO

2. Do you collect data to measure and track key metrics to anticipate arrivals, staffing, and flow?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO

7. Have you hardwired a process to round hourly in reception and treatment areas in the ED?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO

3. Do more than 75% of low acuity patients have a door to discharge time of 60 minutes or less?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO


8. Are you using post-visit phone calls to validate the patient experience?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO


4. Do you routinely calculate the financial impact of reducing your Left Without Being Seen patients?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO

9. Do senior leaders model and hold staff accountable through objective goals and measures for excellence in the ED?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO

5. Does your team consistently use key words to positively impact the quality of the ED patient experience?	<input type="checkbox"/> YES
	<input type="checkbox"/> NO

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