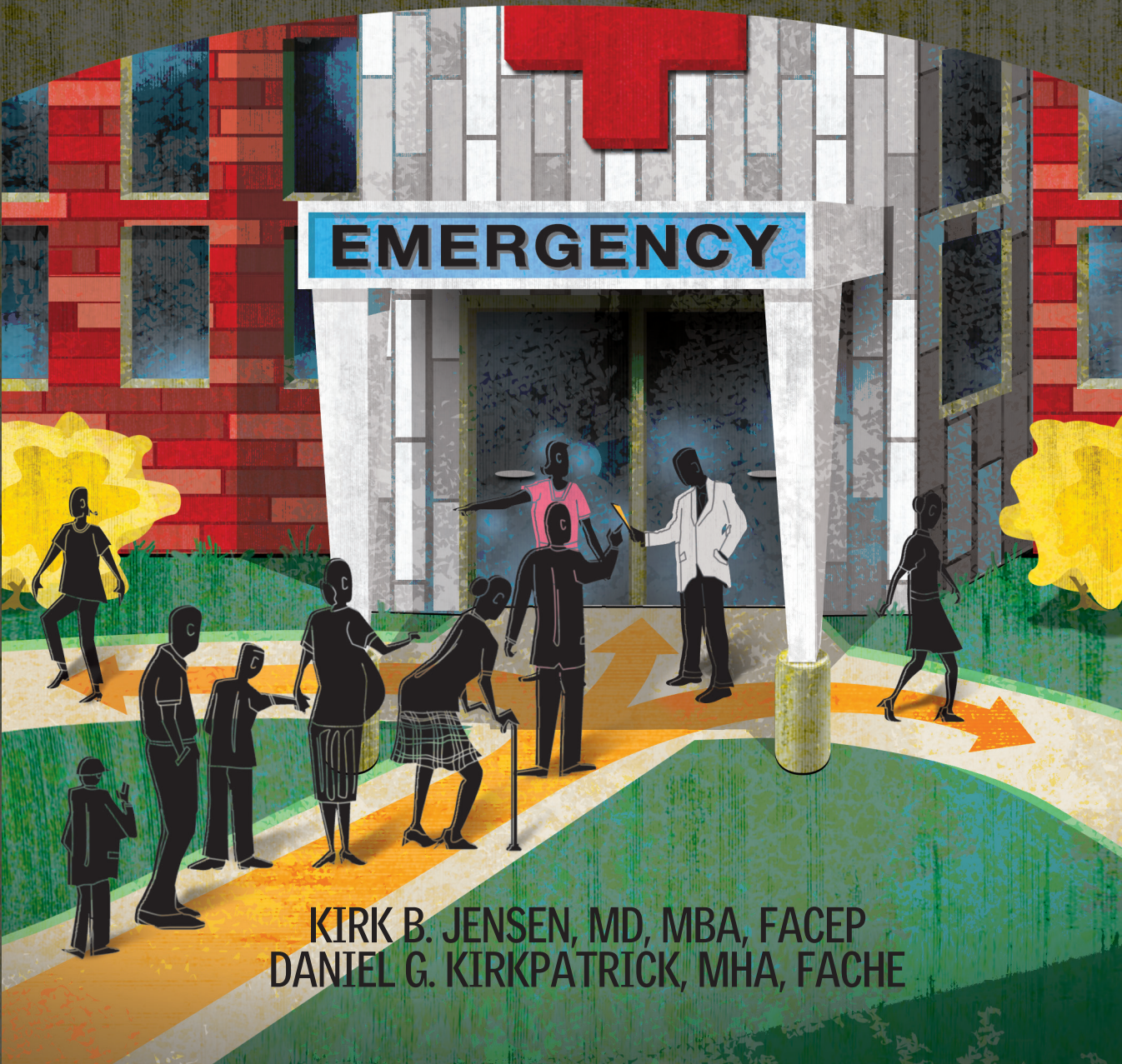
THE HOSPITAL EXECUTIVE'S GUIDE TO EMERGENCY DEPARTMENT MANAGEMENT

Second Edition



KIRK B. JENSEN, MD, MBA, FACEP
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About the Authors

Kirk B. Jensen, MD, MBA, FACEP

Kirk B. Jensen, MD, MBA, FACEP, has spent more than 20 years in emergency medicine management and clinical care. He is board certified in emergency medicine and the chief medical officer of BestPractices, Inc., an emergency medicine leadership and staffing practice based in Fairfax, VA. He is an Executive Vice-President of EmCare, Inc., a leading provider of physician services for emergency departments, inpatient physician services, inpatient radiology management programs and anesthesiology services. Jensen is one of the more widely respected experts in patient safety, performance improvement, and patient flow, and he has developed some of the more innovative solutions in emergency medicine.

Jensen is directly responsible for the coaching, mentoring, and career development of medical directors for BestPractices and EmCare. He also serves as a medical director for The Studer Group, an international outcomes-based healthcare organization, in Gulf Breeze, FL, that assists hospitals in improving clinical and operations results.

Jensen has been on the faculty of the Institute for Healthcare Improvement (IHI) since 1998 and has coached more than 300 emergency departments (ED) through the process of improving operations and clinical services. He chaired the IHI's Learning and Innovation Communities on *Operational and Clinical Improvement*

in the Emergency Department and *Improving Flow Through the Acute Care Setting*, and he currently leads the innovative seminar *Perfecting Emergency Department Operations*. His other accomplishments include:

- Leading two hospitals to national benchmark standards in ED operations and efficiency, while serving as medical director and chair of the ED
- Implementing procedures that achieved national recognition for Nash General Hospital in Rocky Mount, NC, as it was designated a "Best Practice Clinical Site" by the Emergency Nurses Association in 1999
- Serving as a certified MedTeams instructor and expert in Crew-Resource Management (CRM) and patient safety
- Sitting on the expert panel and site examination team for Urgent Matters, a Robert Wood Johnson Foundation Initiative focusing on reducing ED crowding
- Coauthoring the 2008 Hamilton Award–winning book *Leadership for Smooth Patient Flow* and the 2009 book *Hardwiring Flow*
- Contributing chapters to the book *Patient Flow: Reducing Delay in Healthcare Delivery,* Second Edition, Randolph Hall, PhD, Editor, Springer, January 2014
- Contributing to the textbook *Strauss and Mayer's Emergency Department Management-McGraw-Hill January 2014*, as Associate Editor, Section Editor, Operations Section, and coauthor of eleven chapters

- Teaching at the American College of Emergency Physicians Directors Academy, leading ED directors and physician leaders through process improvements in patient flow, patient safety, and managing change

Jensen holds a bachelor's degree in biology from the University of Illinois in Champaign and a medical degree from the University of Illinois in Chicago. He completed his residency in emergency medicine at the University of Chicago and earned an MBA from the University of Tennessee in Knoxville. He also completed the Lean for Healthcare course at the University of Tennessee Center for Executive Education.

Daniel G. Kirkpatrick, MHA, FACHE

With more than 30 years of healthcare management experience and consulting, staff, and administrator roles, Daniel G. Kirkpatrick directs and implements operational enhancements at consulting client sites. As the founder and managing partner of Partners in Improvement, LLC, Kirkpatrick leads and is instrumentally involved in all client engagements, fully committed to the Partners' mission:

> *We promise to be the difference in our customers' day, working to make every connection a personal one. We promise to discover what is important to our customers, respect their choices and customize our services specifically to their needs.*

Kirkpatrick recently concluded over seven years as Vice President of Operations for Best Practices, Inc. In this role he coordinated all operational activities with

site emergency department medical directors in meeting operational/financial goals as well as enhancing service leadership safety and sustainability performance. Prior work experience in public accounting, administrative roles in hospitals (for profit, not-for-profit, specialty medical, surgical and behavioral health) and extensive practice management for medical practices (primary care, specialty and hospital-based practices) provide him sensitivity to the complex issues confronting healthcare providers.

In addition to this book on emergency department management, Kirkpatrick coauthored *The Healthcare Executive's Guide to Urgent Care Centers and Free-Standing EDs* with Michael F. Boyle, M.D. Kirkpatrick has been active in the American College of Healthcare Executives, North Carolina Hospital Association, and is a member of the Emergency Department Benchmarking Alliance (EDBA).

Kirkpatrick holds a BA in psychology from the College of Wooster and an MHA from the Ohio State University. He has extensive experience in serving healthcare providers throughout the United States. He and his wife and children live in Eastern North Carolina.

Acknowledgments

Having the privilege of collaborating on a second addition is wonderful. We've been able to upgrade the content by incorporating new insights, experiences, and "lessons learned." Kirk has long advocated that "every community deserves a well-functioning ED," to which I agree and am fervently committed. I applaud all those ED teams who have been able to appreciate and respect their limitations but not let those limitations define them, their projects, or their enthusiasm. These teams have been able to creatively redefine themselves to achieve remarkable success and improve the services they offer their communities. We've learned a tremendous amount from them and look forward to learning more.

In this same vein, I want to acknowledge my niece, Meghan Kirkpatrick, who, despite having a severely challenging physical ailment, has never let it define her; rather, she has steadfastly persevered and flourished. – Here's to you, Meghan. Two other family members, John Brubaker and Carol Geissler, whose lives were shortened by ALS, persevered, kept the faith, and serve as role models of what *can* be done, rather than what cannot.

Many thanks to Claudette Moore and Raquel Dixon, who have successfully managed this second edition project and balanced meeting timelines while pushing the pursuit of excellence. You guys have been great, and we certainly couldn't have done this without you.

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Kirk Jensen and Thom Mayer have mentored me and exposed me to the nuances and intricacies of emergency medicine. I am forever grateful for their patience and tutelage.

Lastly, a special thanks to all who have chosen to work in the field of emergency medicine. In many regards it's a thankless job where resources are scarce, time is even scarcer, and you're expected to not just instill hope but deliver progress and improvement. Please know you are not alone.

—Daniel G. Kirkpatrick, MHA, FACHE

This book is the result of our combined efforts, knowledge, and experience on the subject of ED management. Our years of clinical practice, mentoring, partnering with, and learning from our patients, client hospitals, and hospital teams across the country have contributed to our current understanding of leadership, management, teamwork, patient flow, and safety and their importance in the lives of our patients, coworkers, and clients.

Many individuals and organizations have contributed to our evolving understanding of how to improve ED operations and management. BestPractices, Inc., EmCare, Inc., the Institute for Healthcare Improvement (IHI), the American College of Emergency Physicians (ACEP) Associates in Process Improvement (API), Lean For Healthcare, and The Studer Group have all provided opportunities to learn, grow, share, and implement positive and productive change. We acknowledge Thom Mayer, Kevin Nolan, Jody Crane, Chuck Noon, and Todd Mungo for their interest and support in our quest. I have personally had the chance to work over the years with numerous leaders and advocates in emergency medicine and healthcare, all of whom have contributed to my understanding of healthcare, process improvement, and change management. For this I will always be grateful.

Dan has already acknowledged our substantial debt to Claudette Moore and Raquel Dixon. Robert Milks was of great help in producing and editing the previous manuscript.

I would like to thank my coauthor Dan for his friendship, collaboration, and insights on this book. I want to acknowledge my parents, Earl and Naomi, who as the parents of eight children first introduced me to the importance of process, management, and organization. My sons Christopher and Michael are constant reminders of what is truly important in life. To my wife, Karen, thank you for your ongoing support, judgment, and wisdom.

—Kirk B. Jensen, MD, MBA, FACEP

Introduction

In the summer of 2013, we were approached to update this book for a second edition, to address the impact of changes in the healthcare system on ED management since the first edition was released in 2010.

The United States healthcare system has experience with capitated payment and shared risk alignment between physicians and healthcare systems. Much of this experience has been useful in aligning improvement on outcomes; however, few of the reimbursement changes have been sustained. With the advent of the Patient Protection and Affordable Care Act (PPACA), we have moved into an era of both shared risk and increased focus on outcomes.

Although we wrote the book originally to address fundamentals of managing the emergency department, some of the recent changes have resulted in new alignments between emergency physician groups and hospitals or healthcare systems and different alignments between the healthcare system and payers. These changes in alignment, or potential changes, require reconsideration of strategic and tactical initiatives in managing the emergency department.

We have updated the text throughout with strategies drawn from our experience in addressing these challenges and new regulations. We have also preserved the majority of the content from the first edition because it provides essential information relevant to emergency department management (actually, quite relevant to

managing most departments within healthcare systems) and forms the basis from which strategies are formulated.

This second edition of *The Hospital Executive's Guide to Emergency Department Management* brings you the knowledge and tools you need to manage your emergency department effectively in the era of PPACA, building in new approaches to support you as you implement necessary changes in both strategy and tactics in managing your ED.

CHAPTER 1

A Design for Operational Excellence

As healthcare organizations are confronted with perhaps more changes than ever (Patient Protection and Affordable Care Act [PPACA], mergers, different payer relationships, etc.), there has never been a more important time to understand, plan, and execute on proven strategies to direct and improve performance in the emergency department (ED). Organizations should implement a comprehensive design for ED patient flow, services, operations, and leadership to ensure their ED provides every patient the finest clinical care in a safe environment and meets or exceeds patient, staff, and physician satisfaction goals.

This chapter provides a design for operating the ED and proven tactics for optimizing leadership to successfully execute strategies for improvement, starting with eight key components that should be included in this design.

Key Components

Before you can devise a plan for improving an ED, you must have a reasonable idea of what the current state looks like. To obtain that requires drawing an accurate picture of what the current department is like.

Making the right ED diagnosis

A critical first step is to carry out an environmental assessment to determine the strengths and weaknesses of the department, what areas need to be fixed immediately, and what areas require planned long-term change for future payoff. Using information gathered during the assessment, along with input from the on-site team, the project leader should sort the ED into one of six categories (see Figure 1.1) and develop a treatment plan.

FIGURE 1.1 A DIAGNOSTIC MODEL

1. **A Major Project:** seriously deficient in all major areas; requires intensive work; success is not assured
2. **A Complete Turnaround:** requires significant investment of effort and time on the part of the management team due to serious deficiencies in staffing, operations, and leadership
3. **A Fixer-Upper:** requires upgrading in just one or perhaps two of the core elements (staffing, operations, or leadership)
4. **Basic Rebranding and Realignment:** requires moderate upgrade in one or two of the major components of the ED program
5. **Leadership Development:** the major deficiency is in leadership; requires upgrading, coaching, or recruiting the necessary leadership
6. **Business as Usual:** "staying the course"—a well-run facility; requires continuing and maintaining the current model

The assessment component should include the following three basic steps:

1. Review of key documents
    - Physician and nurse schedules
    - Patient volume, variation, and trends

- Cycle times for patient flow, subprocesses, and ancillary services
- Patient satisfaction survey results (both inpatient and ED)
- Evaluation and management coding broken down by payer and trended over time
- Review of any previous ED studies (The Joint Commission, risk management, internal review and strategic plan, consulting reports)
- Organizational chart and administrative architecture

2. A two-day on-site operations assessment
    - Interview with all key participants
    - Interview with representative samples of all "service-line" people who provide direct patient care
    - Direct observation of patient flow
    - Direct observation of team interactions
3. Formulation of an action plan and selection of performance improvement teams

Recruiting, credentialing, and retaining your team

We cannot overemphasize how critical recruiting, credentialing, and retention are in establishing a smoothly running ED. Hiring correctly is a cornerstone of quality, safety, and service. Indeed, the most important part of optimizing an ED's development and operational design is recruiting and employing the requisite professional staff. However, hiring the right people is easier said than done. (Hire in haste, repent

at leisure?) You may have to use many approaches in selecting medical professionals, such as:

- Interviewing and assessing those professionals already on-site
- Use of direct mail
- Telemarketing and cold calling
- Advertising
- Word-of-mouth advertising
- Use of professional recruiting firms
- Interaction with various training and professional programs

Recruiting is an arduous process with no guarantee of immediate success. It requires an effective, reliable way to screen for and select the desired attributes. You must rely on professional training, references, personal interviews—and a bit of luck.

Once you've chosen the appropriate medical professional and the job offer has been accepted and secured, the next step is to credential the physician or midlevel provider for hospital privileges as quickly and seamlessly as possible. This process is also labor intensive, requiring coordination by the hospital credentialing service, the group's credentialing staff, and the medical professional.

The optimal goals are to carefully select highly trained and motivated professionals, provide a setting of support, and align their goals with the strategic objectives of the hospital, the nursing staff, the medical staff, and the community.

Leadership selection and development

Equally critical in the success of any ED is selecting and developing effective medical leadership. Because the medical director is the most influential physician employee in

the ED contract group, the administration must carefully select, coach, and mentor that individual. Similarly, the ED nurse manager or director is the most prominent nursing employee in the department, so administrators should just as carefully select, coach, and mentor that person as well.

If you want to succeed in your mission of effectively serving the hospital and its patients, the director is critical to the mission. The leadership team acts as the coach and general manager of the "service franchise." To enable the director to effectively fulfill that role, you must assess, reinforce, and enhance his or her leadership and change management skills. To support your director, you should employ a teaching, coaching, and mentoring process. One recommendation is enrolling the director in a leadership institute for further leadership development, as well as collaboration with peers. As a leader and manager, you should use a balanced scorecard format to continually monitor and evaluate the department and the director's performance.

This scorecard approach focuses on four areas: safety, service, sustainability, and staff. The director and the team must achieve measurable success in all four quadrants to optimize patient flow and service within the ED. In using the balanced scorecard, you set goals and metrics. Weekly conference calls and quarterly ED practice reviews help implement the scorecard and keep it in play.

Patient flow and operations management

Flow can be defined as the movement of people and materials through a service system. In working to improve flow, hospitals apply strategies developed both within and outside of the healthcare industry. Flow is not unique to healthcare, but it is an important element of many service and industrial processes.

We define *patient flow* in the ED as the movement of patients from the time they enter the department until the time they are released or are admitted to the hospital, and if they are admitted, then until the time they are discharged from the ED to the floor.

The following are nine key principles in making patient management more efficient and effective:

1. Match capacity to demand
2. Monitor patient flow in real time
3. Help shape demand
4. Manage, reduce, or eliminate variability
5. Reduce waste (anything that does not add value to the service or to the encounter)
6. Forecast and predict demand for services
7. Understand the implications and insights of queuing and queuing theory
8. Understand the implications and insights of the Theory of Constraints
9. Appreciate that the ED is part of a system

The process of improving patient flow begins with analyzing all the relevant metrics and reviewing all the previous studies of patient flow. It continues with the two-day, hands-on operational assessment we described earlier. The management and operational team should then be guided, coached, and mentored by establishing and coaching performance improvement teams through the production and execution of a process improvement task matrix.

Performance improvement teams play a vital role in the development of hospital processes and relationships. Any critical-care area, such as the ED, the intensive care unit, or the department of surgery, can develop an "us versus the world" mentality. With their particular needs and demands for special skills, these departments commonly become isolated, working as silos. They can easily remain unaware of the work flow, needs, and goals of other interdependent patient care units. Yet this mentality is counterproductive to smoothing flow throughout the unit and integrating flow with the rest of the hospital. Since more than half of the admissions coming into any hospital arrive through the ED, this integration is important.

With coaching and process improvement strategies in place, the ED staff can move beyond its silo and help significantly increase the efficiency and effectiveness of the hospital as a whole.

Customer service and Survival Skills

Patient satisfaction and excellent customer service are critical attributes of high-performance EDs. Patients, medical staffs, and hospital administrators have come to value satisfaction and service as defining features of quality healthcare. Two factors are converging that will likely make the provision of satisfactory service an even stronger driver in healthcare: the fact that consumer culture continues to infiltrate the medical world, and the aging of the baby boomer generation. ED staff members should be trained in these aspects of healthcare. Tools such as our Survival Skills© training course can be used as part of the on-boarding process.

Developed during the past 10 years, the course focuses on the needs of healthcare workers and the attributes and actions necessary to deliver high-quality customer service. Practicing emergency physicians and nurses who are experienced in the realities, limitations, and opportunities present in real-life EDs lead the course.

Survival Skills is augmented by the tracking and trending of individualized patient satisfaction scores and targeted and focused individual coaching. Further, each physician should be recruited with customer service skills in mind, and those skills should be monitored by compliment-and-complaint analysis.

Change management

Improvements mean change, and embarking on cultural change can be quite challenging. It requires patience, humor, and tenacity. Physicians and nurses are not always early adopters of change. They are highly intelligent individuals who are trained to be independent and seldom see themselves as part of a possible problem. When you set out to improve your ED, a significant part of your time should be spent interacting with physicians and nurses, earning their trust, and obtaining agreement on the vision, mission, values, and goals of the department that coincide with their clinical practices. With the right investments in time, metrics, and communication, you can take major steps toward optimizing any ED.

Success in managing change depends fundamentally on a positive, proactive, and evolving relationship with each partner in the clinical provision of care. In the ED, our partners include the hospital, the medical staff, nurses, patients, support staff, and physicians and midlevel practitioners. It is crucial to align strategic incentives among each of these partners to ensure that their needs are met to the best extent possible. The best way to meet those needs is to engage emergency physicians and nurses in an intensive change management process. This process, which was outlined in the American College of Emergency Physicians white paper on ED operations management, delineates the following five steps:[1]

1. Bring dissatisfaction with the present state into the open and create a sense of urgency
2. Communicate a clear vision of the proposed change

3. Promote participation in the proposed change
4. Communicate clearly
5. Maintain the commitment

Organizational change can seem like navigating through swirling rapids. You find your way through them by a combination of diagnostic assessments, team and leadership development, establishing a common vision, creating an ongoing dialogue, and implementing measures and rewards that monitor the process and promote the envisioned results. Always keep in mind that people support what they help create. If they are with you on the takeoff, they will be with you at the landing.

Building a risk-free ED

The key to the successful management of professional liability exposure is not just risk management—which is, after all, dealing with problems after they have occurred—but *risk reduction:* creating, implementing, and monitoring a system that reduces risk by preventing medical errors from occurring in the ED.

To reduce the risk of medical errors, organizations should implement programs that integrate staff education, ongoing Internet training, and continuous monitoring of high-risk areas. With professional liability premiums continuing to rise, establishing a risk-free ED not only enhances patient safety, but also frees up clinical practice revenues for rewarding the clinicians who practice in a safe and measured manner.

Having staff members who communicate effectively and work well together for the common goals of safety and excellent service is critical to risk reduction. We fully embrace the principles of teamwork and training embedded within the discipline of crew resource management. In all of our EDs, the physicians, midlevel practitioners,

and nurses undergo training in teamwork through crew resource management. As with so many successful programs, we achieve success through education, training, mentoring, and focused repetition. An incentive program rewards and reinforces the desired behaviors.

Billing and collection

Billing and collection are traditionally outsourced. The billing process is complicated, requiring a certain level of tenacity, experience, and expertise. Amounting to approximately 8%–15% of revenue, it is one of the largest expenses after wages.

As a staffing company grows, it can consider acquiring or developing an internal billing system as a means to save capital and, in the future, to generate new revenue. Each ED should have on-site office staff members responsible and accountable for ensuring that each chart is signed, properly coded, and promptly sent to the billing component. Any holdup in the charting process will have direct ramifications on the flow of revenue. Coding, billing, and collecting are critical to the success of the operation.

Make a Plan and Stick to It

When you set out to evaluate your ED, you should follow a defined, scripted, and sequenced process. For example, the following is the outline of our On-Boarding™ program on how to evaluate and on-board a new ED affiliate:

- The process takes 6–12 months, with the majority of the work occurring within the first 90–120 days
- Significant scheduled points of contact occur in months 1, 2, 3, 6, 9, and 12

- Scheduled project milestones in months 6 and 12 assess actions and progress to date and include a review of progress with the on-site medical director
- Assessment involves the use of a proprietary balanced scorecard approach, key metrics, and multiple sources of feedback

ON-BOARDING™ ASSESSMENT EXAMPLE

During the first 90 to 120 days, there should be three individualized department assessments that result in three corresponding concrete actions tailored to the facility.

Assessment 1: Patient satisfaction

The first assessment is an in-depth examination of the current patient satisfaction tool and its results. After the assessment, we provide our patient satisfaction and customer service training course and survival skills, with an emphasis placed on those areas flagged as deficient in the patient satisfaction survey. Because patient satisfaction is an outcome of a system, we enroll all the ED staff members—physicians, nurses, administrative assistants, and support staff members—in the one-day course.

Assessment 2: Operations and patient flow

We carry out a two-day assessment of ED operations and patient flow using our ED Metrics Assessment Intake Tool™. This phase involves a previsit assessment of throughput and operations data and a two-day visit in the department. Activities include interviews with everyone involved in operating a successful ED—lab, x-ray, pharmacy, nursing, the medical staff, and hospital management. The operations assessment also includes several hours of direct observations and analysis during the course of multiple clinical shifts. Resulting from this assessment are a preliminary summary of the

ON-BOARDING™ ASSESSMENT EXAMPLE (CONT.)

findings and plans for development of a 6- to 12-month action plan for operational improvements presented to the medical director and the process improvement team.

Assessment 3: Risk management and patient safety

Finally, we assess risk management, using either a survey previously done by the malpractice carrier or performing our own environmental assessment. This stage culminates with our Creating the Risk-Free ED™ course, a half-day, on-site review of the high-risk, problem-prone areas in emergency medicine (an Internet-based version is also available). Again, because safety and risk management are properties of individual and system performance, all key personnel are enrolled in the course. It includes a session on crew resource management or teamwork training, as well as an opportunity for the staff to craft local responses to the issues that arise. Web-based risk-management tools, support, and feedback are also utilized.

Optimizing High-Quality Care

If our goal is to optimize high-quality medical care in the ED, taking a look at how we define quality might be useful. In order to do so, we must return to the following five "rights" of medical care delivery:

1. **The right care:** This topic has been a focus of media attention since Lucian Leape published his seminal article, "*Error in Medicine*," in the *Journal of the American Medical Association (JAMA)*, and the Institute of Medicine (IOM) published *Crossing the Quality Chasm: A New Health System for the 21st Century* in March 2001. With more than 6,000 deaths per year in the

United States alone attributed to medical errors, providing the right care must be the primary concern.

2. **To the right person:** Several high-profile examples, including the case of Jessica Santillan, the patient who received the wrong heart at Duke University Medical Center, have tragically illustrated the importance of delivering the right care to the right person.

3. **At the right time:** The length of stay in an ED is a primary indicator of the quality of care the ED is able to give. When patients wait five hours in the waiting room, the staff *and* the patients have been stressed and tested for five hours before they even see each other. More and more, nurses are working long hours with increased workloads. We know that 75% of medical errors made by nurses on a 12-hour shift come in the last few hours, when they are fatigued. Industry studies dating back more than 35 years have proven that spending more than 10 hours on a specific task creates problems with efficiency and effectiveness.[2] Timeliness in the delivery of care must be a high priority.

4. **In the right place:** Delivering care in the right place is critical for an ED. If patients waiting to be admitted occupy 16 of an ED's 17 beds, those patients are not in the right place. If an ED nurse has three critical patients in ED beds and five in the hallway, those patients are not in the right place. In situations such as these, which are common in EDs, the hospital cannot deliver quality care. We must reshape the system to provide the best possible chance for the patient to have a positive outcome.

5. **By the right people.**

The patient experience

The ED should do all it can to make sure that the patient has a satisfactory care experience. This does not mean that we can guarantee outcomes. Historically, we have talked in healthcare about concrete and measurable patient outcomes; we can deliver very good care overall and yet still have adverse outcomes or patients who are highly displeased with their care.

Medicine has become a scientific, technically accurate practice with practitioners well educated in the science of healthcare. Yet the patient often does not get the healing touch that comes with time spent at the bedside. If patients are not satisfied, they will voice their displeasure to a wide audience and seek care elsewhere.

The ED staff's experience

The key to a positive staff experience lies in having a positive environment in which to work and spending quality time with the patient. First, a positive environment attracts and facilitates retention. Originally, religious organizations trained nurses to be nurturers. Caring for people was the hallmark of the profession. The satisfaction that comes from this experience drew good nurses (and good people) to the profession and kept them there.

As the nursing profession has evolved, nurses are now required to be technical specialists who often have insufficient time to connect with and nurture patients. This has the potential to create an environment high in frustration and low in career satisfaction. The situation can be improved. For example, in one hospital ED, we began with a 33% registered nurse (RN) vacancy rate, and nurses were overwhelmed and overworked. One year later, 11 nurses within the hospital system were waiting to come to work in the ED. Changing the environment by training and grooming the staff with a positive attitude transformed the ED for both workers and patients.

Don Berwick, former president and founder of the Institute for Healthcare Improvement, makes the point that every systematic process is designed to produce the exact results it does produce. For example, if your patients have been waiting five hours, your system is designed to produce that result. If medical errors occur in 20% of your interventions, your system is set up to produce that error rate. If you have 10 admissions per night sitting on gurneys in the ED hallways or occupying your critical-care beds, your system enables that kind of result. If you want a different outcome, you have to change the system.

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