

THE HOSPITAL EXECUTIVE'S GUIDE TO EMERGENCY DEPARTMENT MANAGEMENT



KIRK JENSEN, MD, MBA, FACEP
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Contents

About the Authors..... vii

Acknowledgments.....x

Introduction: Why the ED Matters.....xiii

Why Improvement Is Necessary xv

A Quest for Excellencexix

Chapter 1: A Design for Operational Excellence1

Key Components1

Make a Plan and Stick to It.....11

Optimizing High-Quality Care14

Chapter 2: Leadership.....17

Persuading the High Cs17

What Is Leadership?19

What Leadership Isn't.....32

The Effective Healthcare Improvement Leader34

Developing a Shared Governance Model.....41

Carrying Through: A Seminar Is Never Enough46

Chapter 3: Fielding Your Best Team.....49

Hire Right: A Team Vs. B Team.....50

A Critical Step: Hiring the Medical Director53

The Rest of the Team.....62

Teamwork Attributes, Tools, and Techniques.....62

Chapter 4: Improving Patient Flow.....69

Matching Demand with Capacity.....71

Shaping Demand75

Constraints and Variations in the System78

Teaming Up for Better Flow83

Tools for Smoothing Flow84

The ED Is Not an Island.....92

Flow in the ED: A Final Look96

Chapter 5: Ensuring Patient Satisfaction.....105

The Cost of Dissatisfied Patients107

Improving Patient Satisfaction.....112

Techniques to Satisfy Your Patients115

It Takes a Team125

Chapter 6: Implementing the Plan.....135

Where They Go Wrong.....135

Project Management 101.....136

Reaching the Goal	141
Methods and Pacing	144
Pointers for the Journey.....	149
Chapter 7: Culture and Change Management	157
Breaking Free of Gravity	158
How to Change a Culture	161
Owning Part of the Team	165
Envisioning the Future.....	167
Cementing the Changes	168
Chapter 8: Patient Safety and Risk Reduction	171
Perfection Vs. Improvement.....	172
A Systematic Approach.....	175
Reducing Errors and Preventing Harm.....	178
Chapter 9: The Role and Necessity of the Dashboard	191
Where to Start	192
Clinician Dashboard Metrics.....	197
Summary	198
Chapter 10: Physician Compensation: Productivity-Based Systems	203
Role in the ED.....	205
Heading Off Potential Roadblocks	207

Chapter 11: Billing, Coding, and Collections213

Capturing Missed Revenue.....215

Cash on the Line220

Chapter 12: The Business Case223

Building the Business Case.....224

Operational Quality and Effectiveness.....228

Customer Satisfaction.....232

Sound Financial Management233

About the Authors

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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. Jensen is one of the most widely respected experts in patient safety, performance improvement, and patient flow, and he has developed some of the most innovative solutions in emergency medicine.

Jensen is directly responsible for the coaching, mentoring, and career development of medical directors for BestPractices. 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 seminars *Cracking the Code to*

Hospital-wide Patient Flow and 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
- 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 2007 Hamilton Award–winning book *Leadership for Smooth Patient Flow* and the 2009 book *Hardwiring Flow*
- Teaching at the American College of Emergency Physicians Directors Academy, leading ED directors through process improvements in patient flow, error reduction, 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 recently completed the Lean for Healthcare course at the University of Tennessee Center for Executive Education.

Daniel G. Kirkpatrick, MHA, FACHE

Daniel G. Kirkpatrick, MHA, FACHE, has more than 28 years of healthcare management experience in consulting, staff, and administrator roles, and he leads practice operations at BestPractices, Inc., an emergency medicine leadership and staffing practice based in Fairfax, VA. Kirkpatrick has extensive consulting experience helping group practices and hospitals in meeting their operational and financial goals, as well as enhancing their service, leadership, safety, and sustainability performance. Previously, he worked in public accounting; held administrative roles in hospitals including for-profit, nonprofit, specialty medical-surgical, and behavioral health entities; and provided extensive practice management for medical practices, including primary care, specialty, and hospital-based entities. This experience provided him knowledge of and sensitivity to the complex issues confronting healthcare providers.

Kirkpatrick holds a BA in psychology from the College of Wooster in Ohio and an MHA from Ohio State University. He and his wife and children live in eastern North Carolina.

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A special thanks to my partners in Four Guys—truer friends don't exist.

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 client hospitals and hospital teams across the country have contributed to our current understanding of leadership, management, teamwork, patient flow, and safety, and its importance in the lives of our patients, co-workers, and clients.

Many individuals and organizations have contributed to our evolving understanding of how to improve ED operations and management. BestPractices, Inc., the Institute for Healthcare Improvement, Associates in Process Improvement, Lean For Healthcare, and The Studer Group have all provided opportunities to learn, grow, share, and implement positive and productive change. We would like to acknowledge Eric Minkove, Thom Mayer, Kevin Nolan, Jody Crane, and Chuck Noon for their interest and support in our quest.

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Kirk B. Jensen, MD, MBA, FACEP

Introduction: Why the ED Matters

Acute care settings are often plagued with waits, delays, and dissatisfaction. Nowhere is this more observable and its impact more palpable than in hospital emergency departments (ED). Hospitals are increasingly being challenged to address ED service and quality. A recent report from the Institute of Medicine, *Hospital-Based Emergency Care: At the Breaking Point*, has focused significant attention on this topic. EDs are busy places and only getting busier, and when patients, information, and materials do not flow through the ED in a timely and efficient way, patient safety, patient and staff satisfaction, and hospital bottom lines can all be negatively affected.

This book outlines and defines key challenges, opportunities, and constraints within the ED. We draw lessons from operations and service management and lessons grounded in extensive experience in the real world. We describe the key strategies and best practices that have been developed not only to improve your department but to optimize it. In doing so, we define key barriers and bottlenecks preventing great patient care and we offer solutions to these problems. This book focuses on the following four key drivers affecting ED service and performance:

1. Leadership
2. Service operations
3. The effective use of data
4. Making the right diagnosis and applying the right treatment

Every healthcare leader wants his or her hospital to be successful in a competitive marketplace while providing services that its community requires. An emergency department that works can be a distinctive service that helps leaders accomplish both missions. But many, if not most, healthcare leaders feel they have not achieved this goal in their ED. This is not a result of disinterest or a lack of trying. Most hospital executives are fully aware that the ED is now the front door to their health-care facility, with 50%–70%¹ of hospital admissions arriving through the ED. While some hospital executives may neither like nor want this state of affairs, most understand it is a condition of healthcare today. That's why many have embedded in the hospital's core mission and strategic plan a desire to have a department that they are not only proud of but that they would be willing to visit as a patient or family member of a patient. However, quality, safety, and service can seem fleeting: there for one minute, one day, one shift, or one patient, and then gone the next, seemingly without cause or explanation.

EDs are complex, often chaotic environments—microsystems that can challenge even the best of leaders. EDs contribute to many important aspects of the hospital, such as patient and employee satisfaction, patient safety, risk reduction, evidence-based outcomes, and even profitability. Therefore, it is imperative for healthcare

executives to build processes that can stabilize the ED's performance in the areas of quality, safety, and service. The ED can be, and should be, an asset that gives healthcare systems a substantial service advantage and competitive edge.

Why Improvement Is Necessary

Emergency medicine is a professional and business service that often involves outsourced contract services. But it is only as good as the service it provides—or is *perceived* to provide. Because the ED is the front door of the hospital and accounts for such a large part of hospital admissions, how the department is viewed has a direct impact on how the hospital itself is perceived by the community. A bad patient experience in the ED has a way of making itself known to administration, the board of trustees, and the public. Thus, ensuring that things run smoothly and professionally in the ED is in the hospital executive's best interest.

Traditionally, the nursing management team has run the ED with input from the ED physician group. Nursing staff members are more often than not hospital employees. The physicians may be employed directly by the hospital; however, many hospitals contract with staffing groups or companies to provide physician and management services. A hospital board and administrator have several options when deciding how their emergency care center will be staffed—from small, independent, physician-owned groups to large, nationwide staffing companies. These groups compete on the basis of services provided, economics, and the targeted needs of each hospital.

Historically, hospitals have accepted “good enough” as satisfactory performance from their EDs. But a “gentleman’s C” may no longer be a passing grade, thanks to the baby boomer generation. As this population ages, emphasis will increasingly be placed on the issues of patient safety and satisfaction, risk reduction, timeliness of care, and a satisfied medical staff.

The nature of the problem

On March 31, 2003, the General Accounting Office (GAO) issued a report, *Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities*, warning that the nation’s EDs are under strain and that systemwide change is needed to correct the problems.² The 2009 Report, *Hospital Emergency Departments: Crowding Continues To Occur, and Some Patients Wait Longer than Recommended Time Frames* reaffirms those findings.³ In a survey of 2,000 hospitals, the GAO found that two-thirds of all EDs diverted ambulances to other hospitals at some point during fiscal year 2001. One-third of the hospitals boarded about 75% of their patients in the ED for two or more hours in the previous year, while three-fourths of hospitals experienced some form of boarding.

Both reports suggested that financial pressures lead hospitals to limit capacity, making it difficult for them to meet periodic spikes in demand for inpatient beds. Those same pressures also lead to competition between ED admissions and scheduled admissions, such as surgery patients, who are generally considered more profitable. Herein lies a significant dilemma. If the more profitable cases are not served, less money is available to help meet the space, staffing, and equipment needs of the less profitable cases. Hospital officials indicated that emergency patients are less profitable because a larger proportion of emergency admissions

are for patients who self-pay (including the uninsured) and generally provide lower reimbursement, the study found.

While the federal government has realized that there is a serious problem in EDs and is funding a prominent Institute of Medicine agency to look into that problem, don't expect tangible help in the foreseeable future. EDs need to do what they can to solve the problems of overcrowding and diversion themselves. What do we have control over and what can we do? Consider some myths and realities:

Myth 1: Managed care has decreased ED volume.

Reality: From 1996 to 2006, ED utilization rose by 32%.

Myth 2: ED diversion and boarding patients is a regional phenomenon.

Reality: 75% of all hospitals divert patients.

Myth 3: Nonurgent ED volume has risen dramatically.

Reality: Nonurgent volume has remained stable, while critical-care volume has risen 50% in the past 10 years.⁴

Although all of these myths shape the perceptions and operations of EDs, it is myth 3—that there are too many patients in the ED who do not belong there—that is the most pervasive and persistent. Everyone from the hospital administrator to the average person on the street seems to think EDs are overcrowded because too many patients are treated there who should be treated somewhere else. This perception raises two points:

- Since the federal government, through the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), requires that every patient in an ED be examined and stabilized, what else are EDs expected or able to do for patients?
- Studies show that walk-in volume is not an independent predictor of diversion. Michael J. Schull, MD, for example, found that diversion had nothing to do with walk-in flow.⁵ It had everything to do with how many patients were being boarded in the ED. Staff members in the ED certainly feel overworked or overwhelmed because of the volume of walk-ins, but that is not what causes diversion. Diversion is not a walk-in problem. ED diversion is an inpatient access problem.

A multitude of factors are responsible for crowding, such as:

- ED patients are sicker, but getting patients admitted is more difficult than ever. Hospitals are trying to run at close to 100% occupancy—a factory model where everybody is busy all the time and there is seldom unused capacity. Hospitals aim at maximizing revenues, but without surge or backup capacity, inpatient admissions from the ED can be delayed, resulting in decreased patient satisfaction and other service and safety problems.
- There aren't enough nurses to meet patient demand. The severe nursing shortage is causing nurses to be overloaded. In addition, The Joint Commission has found that this overloading causes 25% of all medical errors.⁶

- Lack of access to on-call specialists can delay care and slow down the admission process. Because EMTALA requires hospitals to accept all cases and transfers requiring a higher level of care, specialists are effectively on call for an entire state or region.
- Many patients using the ED, such as the uninsured, have little or no alternative for medical care. The ED offers these patients high-quality care, access to every diagnostic test the hospital offers, and guaranteed treatment without any up-front cost. These patients will continue to use the ED as their primary care provider until a better system is found.

All of these factors contribute to problems ranging from difficulties with staffing and resources to compromises in patient care and safety.

A Quest for Excellence

The current state of the American healthcare system is obviously a central issue, and national attention is focused on the core issues of patient satisfaction; patient safety; risk reduction; process improvement; risk management; and employee recruitment, retention, and satisfaction. Not surprisingly, these topics have caught the attention of many upper-level hospital administrators as well. Many hospital leaders have turned to industry experts in an effort to integrate safety and satisfaction programs from other fields (such as the aerospace industry and nuclear power facilities) into the hospital and ED setting. The problem (or potential, depending on your point of view) lies in the disparity between the high level of interest in these core issues and the ability to effectively implement and sustain the solutions.

Even in hospitals and EDs where the required competencies are available, the ability to effectively integrate them into a functioning and effective program may not exist.

This book is designed to solve specific problems encountered in an often overburdened and inefficient ED. Our goal is to create unique and replicable processes that ensure increased productivity, safety, and patient satisfaction. And we have not just a goal, but a vision that:

- Every ED will be noted for its commitment to quality and excellence and offer the finest possible service in emergency physician leadership, management, clinical care, patient satisfaction, and patient safety to not only patients but also to hospitals, physicians, and medical staffs
- Every patient will experience and receive this care
- Every healthcare worker (many of them heroes already) will get to practice in this type of environment and facility

The process of elevating the game of your ED to this level and then sustaining that performance is a worthy challenge, one with tremendous potential to improve patient care and safety, as well as to provide returns to the bottom line. We'll define the key operational tools and techniques that have the power to turn every ED into a state-of-the-art practice.

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A Design for Operational Excellence

Organizations should implement a comprehensive design for ED patient flow, services, and operations 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. We've identified 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 you're getting into, and 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 what the strengths and weaknesses of the department are, 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. Yet hiring the right people is easier said than done. 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

It 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 higher 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 director 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 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 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 the 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 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. 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 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 often don't see themselves as part of a possible problem. When you set out to improve your ED, a significant part of your time is going to be spent interacting with physicians, earning their trust, and then 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, patients, and physicians and midlevel practitioners. It is crucial to align strategic incentives among each of those partners to ensure that their needs are met to the best extent possible. The best way to meet those needs is to engage our emergency physicians and nurses in an intensive change-management process. This program, 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 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 of our 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, 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 six to 12 months, with the majority of the work occurring within the first 90–120 days

- Significant scheduled points of contact occur in months one, two, three, six, nine, and 12
- Scheduled project milestones in months six 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 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, and 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 findings and plans for development of a six- 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 administration:

1. **The right care:** This topic has been a focus of media attention since Lucian Leape published his first article about it, *Error in Medicine*. *USA Today* published a full-page article, with photos, focusing on medical errors. 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:** As the case of Jessica Santillan, the patient who received the wrong heart at Duke University Medical Center, so tragically illustrates, delivering the right care to the right person is of ultimate importance.
3. **At the right time:** The length of stay in an ED is the primary indicator of the quality of care the ED is able to give. When patients wait five hours in the waiting room, the staff members have been stressed for five hours before they even see those patients. More and more, nurses are working a 12-hour shift, and we know that 75% of medical errors made by nurses on a 12-hour shift come in the last few hours, when they are exhausted. 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 spending time with the patient and creating a positive environment in which to work. First, a positive environment draws staff members, which in turn contributes to creating more time available for each patient. Originally, religious organizations trained nurses to be nurturers.

Caring for people was the hallmark of the profession. The satisfaction that comes from this experience draws good nurses to the profession and keeps them there. As the nursing profession has evolved, however, nurses are now required to be technical specialists who often have little time to connect with and nurture patients. This has created an environment high in frustration and low in career satisfaction, but the situation can be improved. For example, in one hospital ED, we began with a 33% 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, 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.

References

1. Emergency Department Operations Management: An Information Paper. ACEP. March 2004.
2. Rogers, A.E., Hwang, W.T., Scott, L., Aiken, L., and Dinges, D. The working hours of hospital staff nurses and patient safety. *Health Affairs*. 2004; 23: 202–212.

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