Perfecting Emergency Department Operations

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Our Goals and Objectives

- Identify fundamental challenges and barriers to ED patient flow, operations, and service
- Learn key improvement strategies and methods
- Develop a plan for improving flow in your emergency department
Strategy for Improving ED Patient Flow

Sponsor: Director of Emergency Services
Day-to-Day Leader: QI manager

Goals (measures, performance, by when)

Initial Key Projects
1. 
2. 
3. 

Plans for Next 90 Days

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Tests and Activities</th>
<th>Person Responsible</th>
<th>Completed by When</th>
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<tbody>
<tr>
<td>1st Week</td>
<td></td>
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<td>2nd Week</td>
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Seminar Sessions

The Foundation
- Overview of strategic concepts
- Application of critical emergency department improvement principles

Emergency Department Flow
- Operational strategies for front end/lower acuity patients
- Operational strategies for emergency department throughput
- Implications for emergency department design to optimize flow
- Operational strategies for the back end/accelerating admissions from the emergency department
Seminar Sessions

Operational Strategies for Patient Segments
- Operational strategies for psychiatric patients
- Operational strategies for observation patients

Execution
- Improving emergency department Flow front to back: Kaiser South Sacramento Case Study
- Executing for improvement

Special Topics
Discussion on innovations in emergency medicine

Why do the work?
While there are differing views of health care reform...

The impact and uncertainty of health care reform tops the list of more than one healthcare professional...

<table>
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<tr>
<th>Concerns of Healthcare Leaders</th>
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<tr>
<td>2013</td>
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<tr>
<td>60% expect ED operating margin to decrease</td>
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<tr>
<td>75% identified ED-to-Inpatient BIGGEST bottleneck</td>
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<td>9 out of 10 expect ED volumes to increase</td>
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<td>40 million newly-insured patients from ACA using the ED</td>
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<tr>
<td>2014</td>
</tr>
<tr>
<td>2015</td>
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The Baby Boomers are Here…

Demographic growth is driven by the elderly:

The 65 and older age cohort will experience a 28% growth in the next decade

• One baby-boomer turns 50 every 18 seconds and one baby-boomer turns 60 every 7 seconds (10,000 a day)
• This will continue for the next 18 years

This cohort will comprise 15% of the total population by 2016

A higher proportion of patients in this cohort, in comparison to other age groups, are triaged with an emergent condition

One-quarter of Medicare beneficiaries have five or more chronic conditions, sees an average of 13 physicians per year, and fills 50 prescriptions per year…

Peter Drucker’s Observations on Hospitals and Healthcare …

“The hospital is altogether the most complex human organization ever devised.”
We Know There Are Often Choices to Be Made...

☐ Fast
☐ Cheap
☐ Good

Pick any two.

Moving Toward the Triple Aim...

Improving care, improving health, reducing costs

"Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

The integrator’s role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration."

Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for that population.

Health Affairs 27, no. 3 (2008) 759-769
10.1377/hlthaff.27.3.759Trendwatch
It Doesn’t Hurt to Have Friends in High Places...

TJC and Hospital-Wide Patient Flow

2005 - TJC and the Hospital-Wide Patient Flow Committee: JCR Leadership Standard LD.3.10.10

- The leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.
- Effective for all accredited hospitals on January 1, 2005

2013 - The Joint Commission says “Boarding in the ED requires a hospital-wide solution.”

“*As reported in ACEP NEWS—January 14, 2013

- Performance standards put into effect Jan 1, 2013 require hospital leaders – namely the chief executive officer, medical staff and other senior hospital managers – to set specific goals to:
  - Improve patient flow
  - Ensure availability of patient beds
  - Maintain proper throughput in labs, ORs, inpatient units, telemetry, radiology and post-anesthesia care units

“We want to make sure that organizations are looking at patient flow hospital-wide, even if the manifestation of a flow problem seems to be in the emergency room.” ~ Lynne Bergero, The Joint Commission
HOSPITAL REPORTING OF ED MEASURES TO CMS

1. Median time ED arrival to ED departure - for discharged patients (CY 2013)

2. Door-to-diagnostic (CY 2013)

3. Left without being seen (CY 2013)

4. Median time ED arrival to ED departure - for admitted patients (FY 2014)

5. Median time admit decision to ED departure - for admitted patients (FY 2014)
Quality, Safety And Service Have Always Been the Core Drivers Of Our Mission and Performance...

Increase in patient mortality at 10 days associated with emergency department overcrowding

Dealing with ED Overcrowding

Critical to Quality...

- Door to Doc – the Front End
- Global ED Throughput-Optimizing for Quality, Volume, and Speed
- Managing Flow at the Back End
- Dealing with ED Overcrowding
- Handling Special Patient Populations (e.g. Psych)
Patient Satisfaction as a Measure of Quality...

Satisfied Patients are the Best Measure of Hospital Quality, Duke Study Finds

February 14, 2011

DURHAM, N.C. — Asking your friends and neighbors to recommend a good hospital is the best way to find high-quality care, according to a study from Duke University’s Fuqua School of Business.

The researchers compared patient satisfaction surveys and clinical performance measures, such as administering standardized tests, from two large federal databases. Focusing on three common ailments—heart attack, heart failure and pneumonia—the team measured 30-day readmission rates at roughly 2,500 hospitals. The readmission rate reflects the number of

Timeliness of care has a strong correlation to patient satisfaction (1,2) with wait time to be treated by a physician having the most powerful association with satisfaction. (3)


As a Hospital’s ED Percentile Ranking Increases, So Does Its HCAHPS “Overall” Percentile Ranking*

*Courtesy of a Studer Group analysis
The Opportunity Cost – It Can Add Up

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<thead>
<tr>
<th></th>
<th>1.9 million</th>
<th>$1,086</th>
<th>$9,000</th>
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<td>In 2007, 1.9 million people – representing 2% of all ED visits – left the ED before being seen. These walk-outs represent significant lost revenue for hospitals.</td>
<td>A 2006 study found that each hour of ambulance diversion was associated with $1,086 in forgone hospital revenues.</td>
<td>A recent study showed that a 1-hour reduction in ED boarding time would result in over $9,000 of additional revenue by reducing ambulance diversion and patients who left without being seen.</td>
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Dispelling a Common Myth…

People With Private Health Insurance As Likely To Use EDs As Uninsured:

USA Today (2012) reports that people “with private health insurance” may be “just as likely to use the emergency room as people with no health insurance,” according to a new report by the Centers for Disease Control and Prevention. The report’s findings may surprise some who believe that EDs have become more crowded because more people lack health insurance. However, Sarah A. Berdahl, chief of the Anatomic Studies Branch in the Office of Analysis and Epidemiology for the CDC and the National Center for Health Statistics, “USA Today adds that ‘the findings that either some people are more likely to use the ED and that insurance or lack of insurance doesn’t matter are not surprising, says Angela Gardner, president of the American College of Emergency Physicians.’”

Gardner (2012) reported that “adults 75 and over were more likely to have reported at least one ED visit in the past year than younger people.” The researchers also found that “non-Hispanic black people were more likely to have reported one or more ED visits in the past year than non-Hispanic whites or Hispanics.”

The Business Case for Flow - A Case Study

<table>
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<th>ER Patients</th>
<th>Results</th>
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<tr>
<td>40,000 ED Visits x 1 Hr Reduction in LOS</td>
<td>40,000 Hours of TED Capacity/Year</td>
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<tr>
<td>40,000 Hours of TED Capacity/2 Hours per ED Visit</td>
<td>20,000 potential new visits/year</td>
</tr>
<tr>
<td>20,000 new ED visits x $100/visit in physician revenue</td>
<td>$2,000,000 new revenue for the group</td>
</tr>
<tr>
<td>20,000 new ED visits @ $400/visit for the hospital</td>
<td>$8,000,000 new revenue per year for the hospital</td>
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<tr>
<td>New hospital admissions at $3,000 - $7500 per admission</td>
<td>1 more admission per day (365) X $3,000-$7500/ patient admission = $1,095,000-2,737,500/year</td>
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*(AHRQ-only 6.2% of admissions through the ED are uninsured)*
The Business Case for Flow Continued…

Average $100 NCR MD income for every walkaway

Average $400 in hospital income for every walkaway

For a 50,000 visit ED = $50,000 in new MD revenue (no increased overhead) for every 1% reduction in LWBS/LWBTs

A 1% reduction in walkaways = $200,000 in new outpatient hospital revenue

- In 2007, 1.9 million people – representing 2% of all ED visits – left the ED before being seen (LWBS), typically because of long waits
- These walk-outs represent significant lost revenue for hospitals
- A crowded ED limits the ability to accept referrals

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The #1 Reason To Commit to This Is...
“It’s good for the patients...and it’s good for the people who take care of those patients.”

~ Thom Mayer, MD

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