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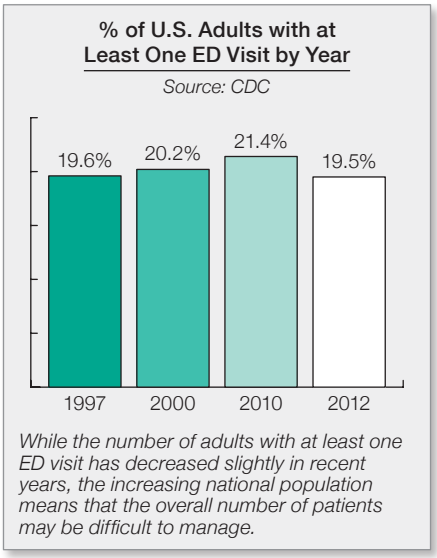
Highlights and Summary of the Executive Roundtable Series: Emergency Department

The emergency department (ED) is often the busiest area of the hospital, as patients who have walked in or been brought via ambulance must be assessed, dispositioned, and treated or transferred in a short amount of time. Each aspect of this process can be an area of difficulty with any inefficiencies potentially resulting in poor scores in patient satisfaction surveys and government metrics. In order to discuss these obstacles to efficient and effective ED care, The Academy brought together top performers from around the nation in the third meeting of the 2014 Executive Roundtable Series.

Organizations represented in the discussion were:

- Cleveland Clinic
- Partners Healthcare
- Dignity Health
- Eastern Maine Healthcare Systems
- Good Samaritan Hospital
- Main Line Health System of Hospital and Health Centers



While the number of adults with at least one ED visit has decreased slightly in recent years, the increasing national population means that the overall number of patients may be difficult to manage.

Discussion Questions:

***Q:** How has your organization structured its ED? Are you using a pod design?*

With the large amount of variation in size, population, and available resources among healthcare organizations, the physical layout and structure of the ED has taken on many different forms across the nation. One interesting distinction is between those organizations utilizing a pod-based design and those using a more open, modular space.

"We have more than 11 EDs under us, so they all have a slightly different design," explained Dr. Seth Podolsky, Vice Chair of the Emergency Services Institute at Cleveland Clinic. "Our main campus is broken into multiple pods, which most of us would say in this day and age may not be

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Preventing Readmissions at an Academic Medical Center

Readmissions have become a critical metric by which the quality of hospitals and health systems nationwide are evaluated by accrediting bodies and payers. Now that CMS ties a portion of Medicare funding to a hospital's readmission rate, organizations are searching for ways to improve the overall health of their patients and by extension lower readmissions. Close to 3,400 hospitals across the country will see their Medicare reimbursements penalized in 2015 as a result, according to an August 2014 report by Bloomberg.

NYU Langone Medical Center has been at the forefront of efforts to reduce preventable readmissions, and has long been a leader in this area among academic medical centers across the country. The Academy spoke with Dr. Martha Radford, Chief Quality Officer at NYU Langone, to learn more about the innovative methods and proven success strategies behind their prevention efforts.

Centering on Readmissions Organization-Wide

"If you look at any academic medical center—but in particular academic medical centers in New York—readmission is more common than average," Radford says. "Readmissions have a lot to do with the type of support that people have or don't have in the outpatient setting."

Access to services and associated care is one facet of a patient's experience that clinicians at NYU Langone consider when they review the cases of readmitted patients. A driving force behind these critical reviews is the question of whether a patient could have been appropriately taken care of without a readmission. Clinicians then consider three phases of the readmitted patient's case: the cause of the initial "index" admission, the preparation for discharge from the index admission, and the care received between the index admission and the readmission. After reviewing the cases of these readmitted patients, caregivers recognized that despite their best efforts, some patients simply required readmission.

NYU Langone MEDICAL CENTER

"Only about 20% of readmissions are potentially preventable," Radford observes. "We're taking care of very ill patients and they may need to be readmitted for many reasons: because their intrinsic disease is getting worse or because they have a scheduled procedure. There are some types of chemotherapy that require readmissions. We're not going to prevent those. 80% of readmissions represent excellent care, so saying that you can prevent all readmissions is not going to get you anywhere."

Much of NYU Langone's success has come as a result of the organization's constant

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the most effective, though it was certainly the trend of the '90s. Some of our newer renovations have more of that elongated race track that's much more open with the ability to expand up as you get busier and then contract down."

Several other organizations represented at the roundtable utilize similar "open space" designs. On the other hand, Heidi Crim—formerly the Nurse Director of the ED at Brigham and Women's Hospital—discussed the many positive benefits that a pod design can offer. "Each of our pods are set up with the same structure," she noted. "All of the staff are competent to care and manage any patient that comes into the ED. Each works independently so there's no need for them to be aware of what's happening in the others—because we set up a system where there is one flow manager over all of them who manages the resources needed."

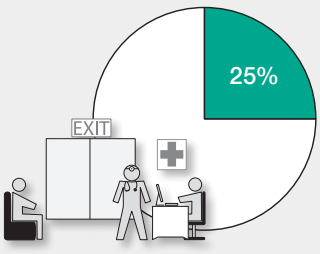
In particular, the concept of a flow or logistics manager was of great interest for many participants. This person's duties involve ensuring that units have the resources they need to complete their tasks in a method that seamlessly integrates with the rest of the department.

Q: Does your organization use "traditional" triage in the ED? If not, have you transitioned to some other model?

ED triage models seem to vary as greatly as structure across the nation. One common alternative has been the use of direct bedding, where patients are brought straight to a bed following a rapid assessment so long as there is available capacity. Other organizations have maintained the use of more traditional triage techniques.

U.S. Emergency Department Visits with Patient Seen in Under 15 Minutes

Source: CDC



Despite continued efforts to make ED care more efficient nationwide, only one-fourth of patients are seen in less than 15 minutes.

"We do traditional triage 24/7," said Mary McCarthy, Nurse Manager at Eastern Maine Medical Center. "We do direct bed but only our acutely ill patients that need immediate care. On an ongoing basis we're full, so sometimes we're stuck with having level two chest pains in our waiting room as we find a bed for them."

Indeed, one of the primary concerns with direct-to-bed techniques that participants shared was for those cases when a patient in urgent need of a bed arrives but the department's available capacity has already been filled. Vicki Potts, Director of Acute Care at Good Samaritan Hospital, explained that their organization—due to its smaller size—must remain constantly aware of their capacity as they utilize direct bedding for high acuity patients. "For that reason, we still do traditional triage," she said. "We stay focused that we put patients in beds right away as needed, but keep some beds open in case of emergency."

Q: How is your organization handling medication reconciliation in the ED without slowing productivity?

Of the topics discussed during this roundtable, medication reconciliation, proved to be the area that most organizations found to be the greatest challenge. Many organizations are using or are attempting to use pharmacists to aid in this process, but some may not have such an individual on staff who has been dedicated to helping in the ED medication reconciliation process.

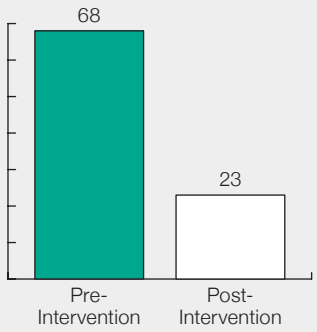
"We have two hospitals with a clinical pharmacist in the ED and one without," explained Kelly Henry, System Director of Regulatory Affairs and Program Excellence at Main Line Health. "There is a proposal to have a pharmacist technician-led medication reconciliation initiative because the pharmacy understands more drug-to-drug interactions and contraindications. We're currently looking into adding more pharmacists to our hospitals across the system."

Organizations looking to improve ED medication reconciliation may also want to consider programs to add pharmacists or get existing pharmacy staff more involved in the ED medication reconciliation process.

Q: How can an observation unit assist with surge management? What are the advantages of having the ED manage the observation unit?

During especially busy census hours, some EDs may rely on a connected observation unit to serve as an overflow area for patients. While this practice is not uncommon, disagreement persists on the best means of managing the observation unit, particularly when being used as an overflow area for ED patients.

Average ED Wait Time from Door to Doctor at Brigham and Women's (Minutes)



Following pod redesign, the average wait time for ED patients at Brigham and Women's fell by 64%; additionally, over half of all ED patients are in a bed within 10 minutes of arrival.

"We do have an observation unit, and we will use it for overflow patients, but it's primarily used for the observation status patients," noted Janet Shepard, Nursing Director for ER and Trauma at Dignity Health's Chandler Regional Medical Center. "We have a 20-bed unit, and we'll usually have a census of at least 30 observation patients, so we try to avoid using the observation area for anything other than those observation patients. We do use the model where the case manager is cross-trained to be a charge nurse and manage waiting observation patients."

Other organizations, such as Brigham and Women's Hospital, actually have an observation unit within their ED with care managed by ED staff. In fact, the hospital recently opened a second observation unit remote to the ED but still operated by a rotating schedule of emergency room clinicians. Through creative use of these resources, Brigham and Women's has seen considerable improvements in its ED surge resolution.

The emergency department is a necessary aspect of care that—by the nature of its purpose—is all too frequently a crowded, challenging area from both a patient and provider standpoint. By investigating the answers to these questions as presented by the roundtable participants and by one's own organization, providers can continue to improve upon the patient and clinician experience in emergent care. ✚

Enhancing Care with Continuous Improvement Boards

Evaluating current workflows in healthcare organizations can be a complex task. It is often difficult to identify issues that are affecting patient care and productivity without involving frontline staff and administrators. Establishing a structured procedure to help improve systems through a continuous improvement board can alleviate some of those difficulties.

Continuous improvement boards are essentially bulletin boards placed in an organization's individual departments to help staff maintain progress on projects to fix inefficiencies seen in the unit. The board marks the growth of an idea for improvement from identification to resolution through titled columns such as "Ideas," "To Do," "Completed," and "Wall of Fame."

In 2011, Lean coordinator of East Tennessee Children's Hospital, Isaac Mitchell, piloted a continuous improvement boards program unit by unit in the organization. In the three years that have followed implementation, the program has succeeded due to detailed staff training and a high rate of program participation.

"This past fiscal year we have improved more than 250 processes with the ideal patient care boards," Mitchell says. "Our goal for next year is to double that. We want to see staff more engaged in continuous improvement throughout the year."

Establishing a Problem-Solving Team

The preparation at Children's Hospital began with training of designated problem-solving coaches. Leaders in training are chosen based on the department they work in or the department they interact with on a regular basis.

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focus on continual improvement at every level. One such improvement strategy was the development of an innovative program called "Partnering for Quality." The program pairs nurse managers and physician leaders at the unit level to develop quality and performance improvement projects at the point of care. Past projects have included improvements in pain management, patient satisfaction, patient education, hospital-acquired condition reduction, and workflow.

Focusing on Discharge Planning and Post-Acute Care

As a result of these continual improvement efforts, NYU Langone has put a greater focus on its discharge preparation to make sure patients understand everything about their care. It also requires a concerted effort to help patients to get the services they need outside the hospital. This typically involves closely coordinating the patient's care with their next caregiver and arranging for specific services, regardless of the post-discharge care venue.

One specific intervention NYU Langone has implemented is a structured post-discharge phone call for every patient. These phone calls are made by social workers and nurses within three days after a discharge or emergency department visit, and are used to gauge the patient's adherence to instructions they were given before leaving the hospital. Hospital staff members discuss a wide range of issues with these patients, generally focusing on assessing common barriers to care, such as if patients:

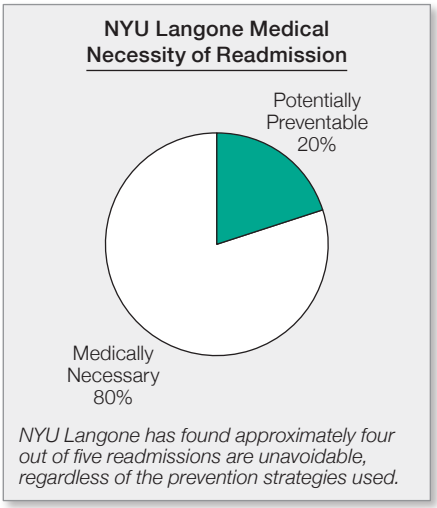
- Received and understand their discharge instructions,
- Obtained and understand their medication prescriptions, or
- Scheduled any necessary follow-up outpatient care.

In this way, clinicians hope to stem any issues that may have previously arisen, such as a complication that develops outside of the hospital setting. The ultimate goal is to transition the patient to an environment that will allow the individual the best opportunity to effectively manage their own care—usually their home.

As a result, NYU Langone has become much more aggressive about arranging for home care services for discharged patients. As Radford notes, the first seven days after a discharge are a particularly vulnerable period in terms of a patient's readmission risk, the organization has made a much more intensive effort to arrange for visiting nurses to see patients in their homes, and arrange for follow-up appointments with a physician.

Providing Better Access to Outpatient Services

Another key facet of NYU Langone's push to reduce preventable readmissions is an emphasis on improving inpatient-to-outpatient care transitions. Making patients aware of the fact that many of the services they receive in the inpatient setting may be more easily and less expensively obtained in an outpatient setting can be very beneficial to the care process.



NYU Langone has found approximately four out of five readmissions are unavoidable, regardless of the prevention strategies used.

"We have a heart failure program that spans the inpatient-outpatient care venues, and they're very aggressive about making sure that the necessary communication happens between inpatient and outpatient clinicians," Radford notes. "They'll call the doctor who's going to care for the patient as an outpatient and make sure that they understand the case."

By streamlining treatment, improving access to care, and focusing on continual quality improvement, NYU Langone has been able to effectively manage preventable readmission risks for challenging patient populations. For an organization seeking to mitigate its preventable readmission rate, NYU Langone's example may prove effective in meeting organizational, regulatory, and patient service goals. ✚

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Coaches undergo a two-day training where they are educated on Lean problem-solving tools. Many of the tools provide the coaches with firsthand experience on the organization's processes through the eyes of staff members and patients. One of the most important tools coaches are taught involves the A3 Problem-Solving Method, which combines Lean's plan-do-study-act model and the scientific method.

The other staff members in the department are given a condensed version of this training by the Lean department. The main goal is to prepare staff to problem solve on their own. The coaches serve as a guide when questions need to be answered, but the solving process itself is primarily staff-driven. Children's Hospital aims to have 40% of the problems be solved by frontline staff, 30% by coaches, 20% by management and 10% by providers.

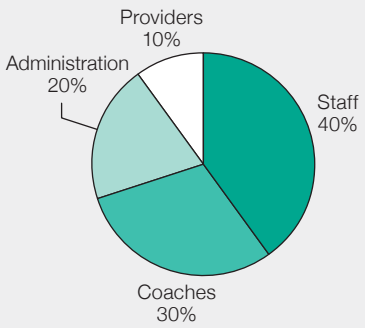
Developing a Set of Procedures

Following training, Children's Hospital staff begins to use the continuous improvement boards as a structured flow process to identify and resolve issues. The full process begins at all-staff weekly stand-up meetings around the board itself. These meetings are held for 15 minutes by a member of the unit to keep ownership of the process with the staff.

Discussion begins with progress reports from the entire team in order to find any resolutions applicable to multiple departments facing the same challenges. After a review of the current projects, the meeting turns to the idea cards that have been recently submitted. Staff members present their ideas on areas that need improvement to ensure that others understand the scope of the suggestion.

After ideas are discussed as a team, the cards move from the "New Idea" column to the "To Do" section on the board. These cards remain there until a staff member volunteers to lead the project. After a staff member volunteers and assumes ownership, the idea card moves to the "Doing" column where it remains active. Once satisfactory progress has been made, the card moves to the "Completed" and "Wall of Fame" sections. The use of columns on the learning board provides a concrete visualization of the problem-solving process.

East Tennessee Children's Hospital Ideal Rate of Staff Driven Solutions



One measure of success for East Tennessee Children's Hospital involves the proportion of problems solved by each level of staff.

"It's a quick visual way to see where projects are in the process," Mitchell explains. "If you put an idea up there and you aren't currently working on the project, you can actually go up to the board and see the ongoing progress."

Challenging Productivity Standards

Organizations may be hesitant to adopt the continuous improvement board program because of perceived productivity losses. Administrators may believe that the time spent on weekly meetings and in identifying and solving problems may detract from the staff members' time to handle their daily responsibilities. However, organizations may actually see long-term increases in productivity in spite of short-term decreases caused by resolving inefficiencies affecting work processes.

"We find when we focus on providing ideal patient care, that productivity, the cost of care, and quality of care tends to take care of itself," Mitchell states.

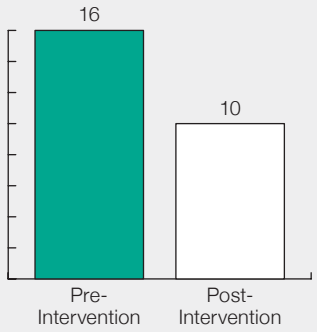
In one example, a regular patient who had monthly blood transfusions was treated as a new patient each month in terms of the care process whenever they came in, which contributed to an average length of stay of 16 hours. The PICU nurses, registration staff, and lab personnel utilized the boards to reduce the patient's average length of stay to 10 hours by pre-registering her before she arrived and completing her blood work the day before the transfusion was to occur.

Children's Hospital's overall savings in resources from the resolution of this problem outweighed the short-term costs that it incurred. More importantly, patient care improved as well.

"In this program we aren't just focusing on big projects," Mitchell says. "It's the culture of the staff coming in every day and saying, 'Hey, we can make small improvements every day.' If we do this day in and day out, eventually we will solve those bigger problems."

East Tennessee Children's Hospital has experienced significant gains in productivity and patient care through adjusted work flow processes identified by staff with the use of continuous improvement boards. By educating staff on problem-solving tools and establishing a structured improvement resolution process, other organizations incorporating continuous improvement boards can experience similar success. ✚

Children's Hospital Transfusion Patient Length of Stay (Hours)



After improving the care process for a repeat blood exchange transfusion patient, East Tennessee Children's Hospital reduced the patient's length of stay by 37%.