



EMERGENCY

Achieving Excellence in the Emergency Department

*Steps to improve the front end, middle, and back end
of the ED to drastically improve performance*

Most Emergency Department and hospital leaders know many of the steps it takes to develop a high-performing ED. But if we all know *what* to do, why are so many EDs underperforming? This white paper offers innovative solutions to “fix” the front, middle and back ends of the ED and unlocks the critical factors necessary to achieve elusive ED excellence.



SETTING YOURSELF UP FOR SUCCESS

Regardless of the specific initiatives you implement to improve your ED’s performance, there are several critical factors you must address first to set your team up for success:

1. Always keep in the forefront of your mind who your customers are. Providing quality care to your patients is only the beginning. The ED medical director as well as every member of the ED team must recognize that they also serve other customers, including the nurses, medical staff and hospital administration.
2. You need to secure buy-in from these customers prior to implementing any changes. Change starts from the top, and administration must be on board with the plan at the start. The ED nursing director and the ED medical director must be a cohesive unit, presenting a united front to all staff members. And the ED physicians and APCs must be committed to embracing new processes.
3. The single most common mistake a new ED medical director makes when managing through change is to say something once and assume it will happen. The reality is that you must be tenacious and persistent, reinforcing the message even after things are “fixed,” as it’s human nature to default back to old processes.
4. Finally, it’s necessary to change a culture that believes “it’s ok to delay.” Change will automatically be met with resistance, and it’s challenging to overcome ingrained beliefs. Again, the medical director must be tenacious and persistent in delivering the message that delays are not acceptable.

THE FRONT END

It’s critical to acknowledge that the ED team completely owns the front end of the process. Triage was initially developed to manage a waiting room at full capacity and has historically been viewed as a nursing responsibility. The ED physician team must accept responsibility for managing the triage process, with a goal of creating a “zero-wait ED.” You must constantly keep patients moving to the next stage without queuing, and patients should never return to the waiting room after being discharged.

Pull to Full

The goal for your triage process should be “pull to full.” Keep pulling patients out of the waiting room and fill up your space in the back, with more acute patients in beds. Should you do triage out front or by the bedside? Every facility is different, and no one size fits all. The key is to remember that you don’t need to do a complete triage immediately, and registration out front isn’t efficient. You can do a bedside triage, quickly obtaining key info and moving on. Triage can even be conducted while walking the patient back to a bed.



Pre-eval Process

The pre-eval process occurs after triage and is critical to continual movement of patients through your ED. Key factors to an effective pre-eval process include:

- When – you launch the pre-eval process when you are at capacity in the ED, either in terms of beds for patients or nursing staff to care for them.
- Where – the exact location for your pre-eval process can change based on your facility, but it's helpful for it to be up front somewhere near your triage area. It should also be semi-private, and it's important to ensure the conversation is scripted: "Our goal is to take care of you quickly and expedite your care."
- Staffing – you should never pull resources from the front end to staff pre-eval. A second nurse (not triage), an NP or PA, or a motivated physician can be assigned to manage the pre-eval process. You must always have someone assigned to pre-eval at the start of every shift. Note that this is different from the "provider-in-triage" model.
- Constant flow – remember, the goal is to streamline the flow of patients. Ensure your pre-eval process area is fully staffed with necessary supplies, and you can use hall beds rather than a room as necessary.

To ensure success, you must: learn the process yourself, ensure the nursing staff is on board, establish a united front between the ED medical director and nurse director, educate staff, and hold people accountable once the process goes live. Keep in mind that your ancillary staff should be aware of your process as well. For example, radiology can pull a patient from pre-eval to start imaging.

Again, the ED team must own the front-end of the process—if managed well, it will have a huge downstream effect on the middle and back ends. By successfully implementing the pre-eval process, it is possible to achieve a 0% LWBS rate no matter the physical size of your ED, your patient volume, or the number of available staffed beds.

In the end, we need to keep in mind why we're doing this. While tracking LWBS, D2P times and LOS metrics are important to discern if you're moving the needle in your improvement efforts, the main driver for change is to recognize that having patients sitting in a waiting room is inefficient, a potential legal risk, and is bad for quality patient care.

Case Study

We assumed management of the ED for Texoma Medical Center, as the CEO was unhappy with the metrics delivered by a large, national staffing company. At the time, the hospital had an annual patient volume of 35,000, a LWBS rate consistently over 4%, and a D2P time of over 90 minutes.

Several changes were made immediately, including implementing a productivity-based incentive model for the physicians, changing the triage process, adding hallway beds, and forcing a pull-to-full mentality. Both the physicians and nurses were now motivated to bring patients back, and the ED has doubled its patient volume to 70,000 without adding additional physical space or physician coverage. The team also achieved a LWBS rate of less than 0.5%, and a D2P time of less than 20 minutes, making Texoma one of the highest performing EDs within the UHS system.

THE MIDDLE

Unfortunately, the ED team does not completely own the middle phase of the process. Turnaround times for lab, CT, X-ray, US, etc., are dependent on ancillary team members and can be influenced, but not controlled. There are several ways ED leaders can influence the middle of the process.

- Clarify roles and processes on the front end: Who collects and transports labs? Who transports for imaging? Will studies be done in the respective department, or can the ED use portable devices?
- Reduce reliance on stacked workups—continue moving patients through the process.
- Establish and widely communicate goals for lab and radiology. You must know and regularly track key metrics like order to lab draw time, lab draw to in-lab time, in lab to result time, UA order to collect, and UA collect to result.
- Conduct monthly operations meetings with all constituents, including CEO, COO, and directors of all key departments, including ED, nursing, lab, radiology, hospital medicine, trauma, etc. Review department goals as outlined above, identify barriers to achievement, and establish solutions as a team. This helps ensure accountability and ownership.
- Conduct a morning "flash meeting" to go through all metrics with directors of each department. This helps to knock down silos, learn what's going on in each department, recognize what your day's resources are, and find short-term workarounds and long-term solutions.

THE BACK END

Most EDs have problems with the back-end of the process. Despite the challenges, we can't use this as an excuse not to fix the front end—we still have control over D2P times and LWBS percentages. As you build credibility with hospital administration as a provider of hospital-wide solutions, it will become easier to suggest strategies to help fix the back end. It is critical for the ED team to help manage the admit process in order to maintain ED capacity for new patients.

Key challenges that lead to bottlenecks include:

- Staffing shortages upstairs
- Transport delays (staff, beds, stat meds, imaging, treatment)
- Bed availability
- Elective surgery schedule, timing and bed assignment
- Lack of clarity around who assigns a bed: bed board, nursing supervisor, etc.
- Housekeeping delays
- Technology delays

Establish an ED Task Force and hold monthly operations meetings to ensure a smooth admit process. To optimize success:

- Ensure this is chaired by the ED medical director.
- Include hospital administration and leaders of each department, including radiology, lab, housekeeping, registration, ICU/tele/med-surg nurse directors.
- Focus on KPI metrics and creating solutions to improved performance, not placing blame.
- Assess each internal process and rework it so that it's patient-centered and maximizes efficiency.
- Bring all 3 phases of the ED patient experience together and hold all departments accountable for performance.

Case Study

We assumed management of the ED for Wellington Regional Medical Center to help improve all phases of the ED process. One of the challenges with decision to admit times was a delay in patients with chest pain, as beds upstairs were not readily available. Patients were waiting 36 hours or more for a bed. We created an Observation Unit upstairs that was managed by the ED team. Through this innovative process, overall length of stay was reduced on average up to 18 hours—almost an entire day less of a patient occupying a bed. Not only did this help to improve efficiency, but it also enhanced clinical outcomes and overall patient experience.

SUMMARY

While the ED leadership team doesn't have control over the entire process, they must acknowledge that they completely own the front end and should play an active role in developing solutions for the rest of the process.

While many hospitals and ED groups know *what* to do to improve, the roadblocks lie in identifying and cultivating the right physician leadership, developing a culture of continual process improvement focused on patient experience, and holding all members of the team accountable for results.

This is a rare skillset, but one that APP has mastered, as highlighted in this quote from one of our hospital client CEOs:

"The key reason for APP's success is their rigorous focus on processes and metrics. While the providers have made a difference for us on an individual level, APP doesn't leave anything to chance and maintains close contact with the physicians, continually working with the provider team to develop goals and drive improvements. It is an entirely different approach to physician management and communication that sets APP apart."

American Physician Partners has performed dozens of ED turnarounds for hospitals nationwide, enhancing performance, volume and revenue.

How can we help yours?

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