ED Service Guarantee
Webinar: Jun 23, 2005

Additional follow-up questions. Responses by Corinne Victor (red) and Randy Benson (blue)

- Can you elaborate on physician extenders? Specifically, what did they do to ensure that patients were ready "to be seen by the physician?"

The extenders only cared for the pt. AFTER the physician examined the pt. and the plan of care was established. Their main purpose was to leverage the physician's time. The NP would perform the laceration repair, the pelvic exam, etc. –anything that would "free up"the physician to go to the next pt. The staff prepared the pt. consistently according to the complaint they presented with. (chest pain, abd. pain, laceration, etc)

- Did you employ any strategies to limit the extent of ED workups conducted in the ED before consulting medical staff will accept patients for admission?

We first had to meet with the Director of Medical Education (this is a teaching facility). As you know, residents "loved "to complete very extensive workups in the ED. We developed guidelines for orders written in the ED.We developed a timeframe that once a pt. was admitted the resident had 30 minutes to complete their evaluation. The ED physician notified the resident ASAP that this was a teaching pt. If the pt. in the ED had a ready bed, the resident would then complete their evaluation on the floor. This was a huge barrier to cross!

Once these guidelines were established, we met with the VP of Medical Affairs and the Chief of Staff to get the suggestions, and subsequent "buy in" to the guidelines. Once this was achieved, the ED Medical Director and I went to the Medical Executive Committee (all the chiefs of the depts.) to introduce the guidelines and gain their buy in. Once this step was complete, we took the approved guidelines to all the section meetings. This was a timely process but well worth it! It helped to decrease the "time to bed" by 60 minutes!!

- Did the hospital have to increase its staff? If so, from what to how many? And were they all full-time?

Yes- they had to increase their staff mostly in the ancillary areas—Lab, Radiology, Environmental Services, Transportation, etc. I do not know the exact number of FTE's that were added, but I do know it was both full and part time.

- Can you describe the staff composition used to implement the 30 minute guarantee? For instance, what were your ratios for the following:

First let me explain how the ED was laid out. There were 4 areas when we started this project- Pod A, B, C, and Quick Care. All beds had hardwired cardiac monitors and computerization at each bedside. All were stocked exactly the same. All rooms were flexible

URGENT Matters

to be able to place any type of pt.in the room. (this definitely avoided the game of "bed bingo!!")

Pod A- 15 beds---ratio was 4:1 (pts –RN)..there were 4 RN's, 2 ED techs (duties consisted of drawing labs, EKG's simple dressings, preparing the pt. for exam/ discharge, vital signs, pulse ox's,placing the pt. on the monitor), 2Transporter/ Stockers(they were not clinical in nature at all—they stocked their pod, did the non critical transports to the floor, x-ray,etc), 2 ward secretaries,(all clerical-called doc's, labs off the printer onto the charts, etc) 1 Advanced Paramedic(A-EMT- they started IV's, labs, EKG's, discharges after the physician explained the instructions to the pt., gave ACLS drugs in codes, plus other simple meds)

Pod B-12 beds in this Pod. This is where the trauma and resuscitation rooms are located. These are the acutely ill pts. Staffing is 3: 1 here –so 4 RN's, 2 ED techs, 1 A-EMT, 2 ward secretaries, 2 Transporter/ Stockers

Pod C- 14 beds-The Pediatric ED was housed in this Pod.—10 beds for Peds—4 beds for overflow from the Quick Care area. The staffing in this Pod – 2 RN's (Peds ED trained), 1 A-EMT, 1 ED tech, 1 Ward secretary, 1 Transporter / Stocker. The acuity in this area was lower due to the Peds volume.

Quick Care- 12 beds plus the 4 from Pod C as overflow. This area denotes that it was an "Express Care"—it was not. All pts upon arrival to the ED were placed in one of these rooms, the assessment completed, and the physician exam done. If the pt. had to remain on a cart, or required further evaluation, they would be moved to a bed in the other Pods-followed by a physician and nurse in the back. Report would be given from the Quick Care area to whichever Pod they were transferred to. This area is constantly moving. Your best nurses and physicians work out here. This is where the process begins. If this area gets bogged down, the process will not work! It is heavily staffed for this reason! On a day with 300 pts 26% of them are admitted---the majority of the pts. could have been discharged from the Quick Care area. The beds in the back were kept for the 60 admissions / day, the EMS runs, or transfers from our other facilities. It wasn't unusual for the QC area to have a code though. As we know, acutely ill pts.can be driven to the ED- or walk in.

Staffing in QC- 3-4 RN'S, 3 A-EMT's, 3 ED techs, 2 transporter/ stockers, 2 ward secretaries

There were also 2-3 RN floats that relieved for breaks, or would pick up a nurses assignment if they were caring for a critical pt.

- MDs to patient volume? Physician extenders to patient volume?

There were 6 Physicians on during peak time… 2- QC—one always 24 hrs / day—2 from 1000- 0200; 2 Physicians in the back for Pod A & B. –they were stationed together-they went to the pt.; 2-Pod C. The NP's were as follows: 2 at QC 1130-2400, 2 in the back Pods-1130-2400. MD pt. volume was around 2.0-2.2 pts/hr/doc. The NP's did not have a volume expectation—only to leverage the physician time.

- RN to MD?-see above
- RN to beds?-see above
- Techs to RN?-see above

- We are in a market of two urban hospitals that service a large population of underserved people and also patients who come into the city from a large outlying suburban area with some outlying smaller hospitals. Our hospital lost money last year. How can we increase satisfaction in such a way that we will attract in patients from the suburbs out of proportion to the less fortunate local people? A service guarantee risks increasing our market share of the underserved which could inundate us and mean we would lose more money than we do now.

First you have to improve not only the operations, but the caregivers need to project a happy and compassionate attitude towards the pts. As sappy as that sounds, the only way that the "word of mouth" will improve in the community is the way the staff project themselves. You can have the most aggressive marketing campaign ever, but with poor attitudes, it doesn't matter! Once the word of mouth has improved, you will have pts. willing to drive an extra 15-30 minutes to be seen and treated quickly by caregivers who want to be at work! Your lower levels may increase, as did ours, but you will see a dramatic increase in your sicker pts.!

Attracting people from the suburbs has a lot to do with access to transportation. Relatively more affluent patients/families can use their car to get to your hospital relatively quickly. Those that rely on public transportation, disproportionately the underserved, will spend more time and effort getting to your hospital, thereby undercutting the advantages of the shorter waits you would offer.

- We all know that it takes people to make the outcomes happen. What creative things did you do to achieve buy in from:

    - 1. The provider staff. - I met with each and every physician in the ED. I understood implicitly their "wants and needs", but conversely, they understood my goals and vision of where the ED needed to go. You must have a very proactive, not reactive ED Medical Director willing to take accountability for the actions of others. Once we were all on the same page, the docs were assigned to the teams to design the new process. This truly gained their buy in.!

    - 2. Nursing staff.-The same methodology was applied to all staff as to the docs. Interviews were conducted; my vision and goals were shared with all of them. Right from the inception of these teams, it was stressed over an over again that CHANGE MUST TAKE PLACE!! That we must change the way we that we delivered our care. Some staff got out right away—the majority hung in there until the end. They wanted to feel good about coming to work!

I also asked different interested pts/family members who were previously treated in the ED to sit on these teams and help to develop the process “from their eyes!” This was definitely an “awakening experience” for the staff to have the pts, sitting on the teams with them side by side!!

- 3. Administration-The Executive Leadership set the tone for this project. It was stressed from the beginning that the ED is the front door to the hospital—that change will occur, etc. We invited the Nursing managers, Lab, Radiology managers, etc to be on a team that was redesigning the ED flow and processes. It was again stressed that the ED is a “System, not just a Department”. We needed everyone who touched the ED pt to give us their ideas and feedback.

  We also built an economic model for administration, showing that the ED was a bottleneck for profitable admissions to the hospital. It was clear from the model that there were huge economic advantages to improve the throughput in the ED and use the service guarantee to let the community know what they could expect.

- What is the time frame that it took for the hospital to implement from idea concept?

  The kickoff presentation was in January, 1999.The guarantee was implemented in July, 2000. But remember, the entire ED process , along with lab, radiology, environmental services, nursing on the floors, etc processes were also changed! We were not trying to meet a deadline in this endeavor---we wanted to cover all bases, so in the end, the process would be sustained!!

- What constitutes “seeing a physician" within 30 min -- can the physician just poke his/her head in and say hello or do they have to examine the patient?

  No---each and every pt. is seen by the physician first and examined, and then the care will be initiated within 30 minutes!

- Is the patient always seen by a physician within 30 minutes? or is a physician defined as NP/PA/ or MD.

  The ED physician always sees first—the NP would be called in to do the laceration, pelvic exam; etc…--after the exam by the doc was completed!!

- Did you increase total number of physicians/physician extenders to achieve your goal. What is your PA/MD/NP ratio to patient visit?

  The number of physician hours had to almost double. We never used the NP’s in the ED until we started this process. 2.0-2.2 pts/hr/doc was what we ran. Again, the NP’s did not have a volume expectation---just leverage the physicians’ time—the docs drove this process. They were the Captains of the Ship!

- Can you describe the process when the hospital was at capacity, i.e. no beds available? How did your intake process change? Did staff do things differently or did you just assessed patients in the hallway?

  The intake process never changed. The pts came into the QC area. Unfortunately, hallways had to be used once it got busy in the back pods. The stable pt. waiting for tests would be moved into the hallway awaiting disposition.

  By the way, the hospital created a task force, as part of the ED project, to bring on line every licensed bed in the hospital.

- I am interested it hearing more about the team model triage. Can you elaborate on roles and responsibilities?

  -please see above answer where description of staffing patterns, etc occurred.

- You mentioned five questions at initial registration, can you repeat them? And when did Admitting get the remainder of their registration information?

  They were as follows: Name, SS#, Birth date, complaint, and private physician's name. Admitting would get the rest of the information only after the exam and care was initiated. It could be on the way out the door. We utilized different colored demographic sheets to alert the staff and physicians that the registration needed to be upgraded. It was also in our tracking system on all computes. It was designated as an "M" for mini reg— or "R" for complete reg .

- Were your MDs hospital employees or independent contractors? Are they employed on a fee-for-service basis or salaried?

  They have always been independent contractors. They were fee for service, but had to change to salaried with different incentives built in according to measures that we set up. (Pt., attending physician, staff satisfaction; the LBE's, diversions, etc.) They were held to the same standards as the goals of our scorecard.