ED Management®
Best Practices – Patient Flow – Federal Regulations – Accreditation

AHC Media LLC

Emergency department decreases 4-hour wait times to 9 minutes

Rapid evaluation unit model was most important driver

Not long ago, the ED at Palisades Medical Center in North Bergen, NJ, was struggling with waiting times hovering at about four hours. "Like every other ED, we struggled with long waiting times — especially on the 3 to 11 shift," recalls **Maureen Coccaro**, MS, RN, one of two clinical coordinators of the ED. "If you had six people come in at once, with the old traditional approach it would take a nurse 10 minutes to triage each patient, so the last person to arrive would be waiting an hour."

The ED, which sees 35,000 patients a year, replaced that "traditional" approach with a rapid evaluation unit model. The results? Door-to-doc time is now at around nine minutes. "We still do triage, but we have brought it to the bedside," she explains. "That has freed up the front end." **(Even when you are performing a rapid triage process, warns Coccaro, you still must obtain a thorough history. See clinical tip on p. 3.)**

Special focus: Secrets of improving patient flow

Patient flow is an issue that continues to plague ED managers as patient demand outstrips capacity. However, several creative managers and their staffs have developed successful strategies for improving flow. In this *ED Management* special issue, you'll hear from many of them:

- an ED manager who has teamed with the hospital patient flow specialist to create effective strategies inside and outside the ED;
- a department that switched to the rapid evaluation unit model and reduced door-to-doc time from four hours to nine minutes;
- an ED leader who already had admirable flow numbers but decided that "good" wasn't good enough;
- a telepsych program that eliminated the need for patients to wait long periods of time — sometimes overnight — to be seen by a psychiatrist.

We hope that enjoy this special package we have put together and that inside these pages you will find innovative strategies that you can put to work in your ED. ■

IN THIS ISSUE

Financial Disclosure:
Author Steve Lewis, Senior Managing Editor Joy Dickinson, Associate Publisher Coles McKagen, and Nurse Planner Diana S. Contino report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Executive Editor James J. Augustine discloses he is a consultant for The Abaris Group and conducts research for Ferno Washington. Caral Edelberg, guest columnist, discloses that she is a retained consultant for TeamHealth and that she is a stockholder in Edelberg Compliance Associates.

JANUARY 2010
VOL. 22, NO. 1 • (pages 1-12)

When a patient first arrives at the ED, he or she now is met by a greeter, who is a clerk and will perform a quick registration. That registration gets the patient into the medical records system. The greeter then will bring the patient into the rapid evaluation unit and hand him or her off to a nurse. The patient is triaged at the bedside by a nurse, a physician's assistant, or a doctor.

"This gives us the opportunity to order whatever the patient needs then and there," Coccaro says. For example, there is no wait for the lab to pick up the blood. Lab work is sent via a newly installed pneumatic tube. **Gladys Sillero**, MSN, RN, CNS, APN-C, clinical nurse specialist and the other clinical director of the ED, says, "Some of our nurses' aides were educated in how to draw blood and they are nurse technicians now, so we can do bedside tests like glucose levels."

Coccaro says, "We can also discharge the patient with instructions more quickly, since we have a nurse both on the front end and at the back end." In spring 2008, the hospital started looking at processes and how the staff could better flow patients, Sillero says. She notes that hospital and ED leadership approved the hiring of a consultant from Woodbury, NJ-based Emergenuity, to work with the ED.

In addition to the rapid evaluation model, says Sillero, the consultant recommended dividing the ED into two areas: one for walk-ins and low-acuity patients, and the other for those who required a full work-up. "The patients are usually admitted from that area," she explains.

Furthermore, the ED staff members have been communicating with the other departments about their work flow and how it affects the ED, Sillero says. "We've started doing morning rounds and getting together an interdisciplinary team to expedite care and discharge patients more quickly," she says. "I think it has helped a lot." Sillero says the team includes herself and Coccaro, a charge nurse, other nurses, physicians, physician assistants, ED techs, nurses' aides, a social worker, and a case manager.

While the ED staff agree that the installment of a rapid evaluation unit model was the major reason they were able to get door-to-doc times down to nine minutes, they note that smaller, less "glamorous" changes

Executive Summary

The ED at Palisades Medical Center in North Bergen, NJ, has slashed its door-to-doc times down to nine minutes with the implementation of a new rapid evaluation unit model and other improved efficiencies. Here are some of the keys to their success:

- Triage was moved to the bedside, where specially trained nurses' aides perform point-of-care testing following evaluation by a nurse, a physician's assistant, or a doctor.
- Discussions with other departments made them aware of how their processes affected ED wait times.
- A discharge area was created to free up more beds in the ED proper.

ED Management® (ISSN 1044-9167) is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***ED Management***®, P.O. Box 740059, Atlanta, GA 30374-9815.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 12.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 12.5 Contact Hours.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 15 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit.

This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 24 months from the date of the publication.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291 (customerservice@ahcmedia.com). **Hours of operation:** 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST. Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482.. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $82 each. (GST registration number R128870672.)

Editorial Questions

For questions or comments, call Joy Daughtery Dickinson, (229) 551-9195.

Editor: Steve Lewis (steve@wordmaninc.com).
Associate Publisher: Coles McKagen (404) 262-5420 (coles.mckagen@ahcmedia.com).
Senior Managing Editor: Joy Daughtery Dickinson (229) 551-9195 (joy.dickinson@ahcmedia.com).
Director of Marketing: Schandale Kornegay.
Senior Production Editor: Nancy McCreary.

Sources

For more information on rapid evaluation units, contact:

- **Maureen Coccaro**, MS, RN, ED Clinical Coordinator, Palisades Medical Center, North Bergen, NJ. Phone: (201) 694-6159.
- **Gladys Sillero**, MSN, RN, CNS, APN-C, Clinical Coordinator, Palisades Medical Center. Phone: (201) 854-5761.

also made a significant contribution to their success.

For example, "We had just done over the back part of the ED to assist us with flow," says Coccaro. A discharge area was created and equipped with "stretcher-beds," a TV, and magazines so that patients waiting for X-rays or discharge instructions did not have to wait in the patient care area. Those beds could be used by new patients.

Coccaro says additional flow time was freed up with another simple change. "Before, every patient was brought in on a stretcher," she notes. "Now, they are brought in on a stretcher only when it's necessary. We have comfortable chairs for people with less serious illnesses or injuries to sit on."

When all patients were brought in on stretchers, they were also all put into hospital gowns, which took time, "and many patients do not need all that," she says. **(For information on how the ED improved length of stay, see story, below.)** ■

D-to-D improved — It's on to LOS

Not content with slashing wait times from over four hours to about nine minutes, the ED staff at Palisades Medical Center in North Bergen, NJ, is redoubling its focus in another area: length of stay.

"We are at four hours, or a little below, and we're working to get it down to three," says **Maureen Coccaro**, MS, RN, one of two clinical coordinators of the ED.

Gladys Sillero, MSN, RN, CNS, APN-C, clinical nurse specialist and the other clinical director of the ED, says, "At one point, it was greater than five hours. At most hospitals, four to six hours is the norm."

In addition, Coccaro says, "We just put in a new documentation system for both doctors and nurses." The Picis ED PulseCheck system is manufactured by Wakefield, MA-based Picis (www.picis.com). "It's relatively new, but what we're trying to do is improve patient safety by eliminating legibility problems associated with handwriting, and also ensure better flow while the patient is in the ED," she notes.

Coccaro is convinced staff resistance will not be a problem as changes are made. "People do not like to change from old modalities," she concedes, "But we have a mixture of seasoned and younger staff, and they have worked together well as a team." ■

Clinical Tip

Don't overlook need for accurate history

Even if you are performing just a quick triage, you always need to make sure you listen to the patient and obtain a thorough and accurate history, advises **Maureen Coccaro**, MS, RN, clinical coordinator of the ED at Palisades Medical Center in North Bergen, NJ.

"The patient is always the best historian, and you can never let that go," she says. ■

Flow strategies cover processes in and out of ED

Door-to-doc time drops 16 minutes

Because many throughput problems experienced by EDs are not *caused* by EDs, those managers who find themselves operating in a vacuum have little chance of success. Cincinnati Children's Hospital Medical Center can point to a comprehensive approach to improving flow that addresses ED-specific issues and hospitalwide issues — and to an effective partnership between the ED manager and the hospital's patient flow expert.

"We look at flow from two different perspectives: flow *through* our department and flow *out of* our department," says **Julie Shaw**, RN, MSN, MBA, CEN, senior clinical director of the ED. "Our pediatric ED admits fewer patients [into the hospital] than an adult ED would, so internal flow is important to us, and of

Executive Summary

With changes in place only about six months, Cincinnati Children's Hospital Medical Center, compared the May-July period door-to-doc times and found they had dropped from 61 minutes in 2008 to 45 minutes in 2009. The ED manager interfaces with the hospital's director of patient flow, and they have initiated new processes inside and outside the department:

- Nurses have been placed at the ED entrance to take a "quick look" at patients.
- Handoffs are handled via fax, so ED nurses no longer have to track down their inpatient counterparts for a telephone conversation.
- Mathematical formulas have been created to predict admissions and discharges.

course, when we do decide to admit and send children to the inpatient area, external flow becomes important, so we've had some efforts in both areas."

Shaw has been working with **Pamela Kiessling**, RN, MSN, director of patient flow & clinical integration, clinical & business integration, and patient services. "Our goals throughout all of this is that patients should not experience delays," says Kiessling. "We want to deliver timely, efficient, effective care."

Although the changes have been in place for only about six months, the hospital already is seeing results. Comparing the May-July period door-to-doc times have dropped from 61 minutes in 2008 to 45 minutes in 2009.

The ED has tried several strategies to address internal flow and had to abandon some of the earlier attempts, says Shaw. "We tried the idea of having a physician in triage, as well as a nurse whose main assignment was managing flow," she says. "We used those two in tandem with each other, but it was not sustainable in terms of personnel. The ED docs were not able to keep staffing levels high enough." **(Other hospitals have found success with having a physician in triage. See these *ED Management* stories: "Care Initiation Area yields dramatic results," March 2009, p. 28, and "EDs must learn from past to solve nagging problems," January 2009, p. 5.)**

One of the more important initiatives implemented began in January 2009, Shaw says. "Under our old system, when the patient arrived, there was a clerical person who was the first person the patient saw when they came in the door," she says.

Now, Shaw says, every patient is seen by a nurse immediately upon arrival for a "quick look." "She asks a few questions, such as if they are in pain," says Shaw. "She also determines if they need immediate help, such as resuscitation, and if so, they move them into the resuscitation area." If they don't require such immediate help, they then go through a more complete triage process.

Shaw says the changes have ensured a safe flow as well as a smoother flow. "We do a high-level immediate sort before triage — meds, allergies, history — so patients with significant respiratory distress, bad fractures, those requiring pain management, all those get recognized right away," she says.

Data on door-to-doc times and length of stay still are being formalized.

Addressing external flow

Ironically, one of the greatest challenges to external flow grew out of an effort to improve safety.

"We developed safe handoff care with the three general care units that represent the greatest 'exports' from the ED, but when we put it in place, ED wait times grew exponentially," says Kiessling. "Handoff was blamed, and the thought was that we just had to accept it, but we couldn't. For us, two hours is a really long time."

So this year, an interdisciplinary team of test units and involved departments have been "mapping" the entire process, Kiessling says. "We looked at nonvalue-added steps and tried to eliminate those," she says. "We tried to decrease redundant or unnecessary communication points." Thus far, one of the steps that seem to have made a difference is removing the nurse-nurse verbal report and replacing it with a faxed report, Kiessling says. "The opportunity to question and clarify is still there, but it is positively impacting wait times: In our small tests of change, we reduced the bed request to occupy time by as much as 40 minutes," she says. "It eliminates the whole telephone-tag situation you get with two people who are busy." **(Kiessling had implemented several other strategies that are helping improve ED flow. See the story on p. 5.)**

This was "a major culture change," says Shaw. How was it accomplished? "First, we had significant support from leadership on those three units as well as the lead level above them, the assistant vice president to whom they all report," she says. "Everyone wanted make the process better."

The initiative advanced incrementally. First, it was tested on one nurse and one patient. Next it was tested on one team, then on the entire unit, then for a whole day, then on two units, then for 16 hours a day with two units, and so forth. "It's the whole PDSA [plan-do-study-act] quality improvement process," says

Sources

For more information on internal and external flow strategies, contact:

- **Pamela Kiessling**, RN, MSN, Director of Patient Flow & Clinical Integration, Clinical & Business Integration, and Patient Services, Cincinnati Children's Hospital Medical Center. Phone: (513) 636-8678. E-mail: Pam.Kiessling@cchmc.org.
- **Julie Shaw**, RN, MSN, MBA, CEN, Senior Clinical Director, Emergency Department, Cincinnati Children's Hospital Medical Center. Phone: (513) 636-8517. Fax: (513) 636-3943. E-mail: julie.shaw@cchmc.org.

Shaw. "We went back and did daily huddles, saw where we were failing, and made changes. For example, we learned we had to pull the patient escort folks in as part of the group."

The patient escort staff move the patient from the ED to the floor, notes Shaw. "We might be working to handoff and transfer in a timely manner in the ED and on the receiving floor, but if the patient escort department is not focusing on the same need for timely response when a transport was requested, it can erase the gains made in other parts of the process," she says. "The patient escort leadership was able to educate their staff, change some supervision patterns, and change the priority of ED transport calls in our electronic system that handles requests for patient transports to ensure priority was given to ED requests. This helped us with consistency in response time and maintaining and sometimes improving on gains made with other parts of our improved process."

For the first couple of weeks, says Shaw, "we had handwritten data collection forms, and the leadership in all units was very involved talking to the nurses about how things were going, what was working, and what wasn't." When you start with small tests, "you can talk and bring information back to the table every single week," she says.

The units still meet weekly in an ongoing improvement effort, Shaw says.

The testing started last summer, she continues, "and we've had some success with decreasing [the handoff] piece of the transfer time." **(No matter what system you use for handoffs, it's critical that you focus on current issues, says Shaw. See clinical tip on p. 6.)**

The H1N1 outbreak ironically helped engender the needed culture change, Shaw says. "Our clinics expanded hours," she says. "We were running an overflow clinic to funnel off patients who were not high-level emergencies, and it kind of pulled the whole organization into thinking about what kind of things they do in their areas to support patient flow time in this area." They now understood that they were an important part of ED flow, because it was affecting them and their families, she says. "I couldn't have planned it, and I certainly wouldn't have asked for it, but we tried to optimize the opportunity to have everyone be involved," Shaw summarizes.

Overall, she says, "Our LOS actually holds steady across the past three years, which probably makes sense since the triage flow processes that we changed are very early in the patient encounter, and many other things would affect overall LOS," Shaw says.

What's most important? "The patients are getting where they need to go in a more reliable manner," Shaw says. ■

Predicting admits, discharges vital

The numbers don't lie, and having a handle on the numbers is a critical part of developing effective strategies for improving patient flow, says **Pamela Kiessling**, RN, MSN, director of patient flow & clinical integration, clinical & business integration, and patient services at Cincinnati Children's Hospital Medical Center.

"We knew that we were not as efficient as we could be with the whole process around discharges," Kiessling recalls. "For those who just needed antibiotics to take at home, for example, we did not plan in advance sufficiently to discharge them as soon as they were ready to go."

To improve in this area, you have to be able to predict discharges, she says. "The adult world has been doing this for a long time because of their payer structure. Pediatric facilities are paid differently [i.e., in terms of DRGs], so we have not been driven to be as proactive," Kiessling says. "But now we're doing it for the right reasons: to have the patients leave on time and have no delays."

Discharge prediction is a two-level process, Kiessling explains. First, the patient has to have discharge criteria. Goals need to be specific and well communicated to the entire team, including the patient and family. The second level of readiness has to do with the team tasks that need to be completed, such as home care arranged, prescriptions written, and orders written. "The goal is to have the team tasks completed prior to the patient's readiness for discharge whenever possible so that there is no delay for the patient once she or he is ready to go

Clinical Tip

Handoffs must focus on current issues

Whether face to face, on the phone, in a written report, or by other means, it is key that patient handoffs focus on current patient problems and care — or follow-up needed in the time immediately following the handoff, says **Julie Shaw**, RN, MSN, MBA, CEN, senior clinical director of the ED at Cincinnati Children's Hospital Medical Center.

"A standardized hand-off process will help clinicians provide consistent information every time. An opportunity for questions and clarification is needed and should be focused on immediate care needs," she says. "A process that allows for communication that does not create flow delays is also essential." (At Cincinnati Children's, a fax handoff system has helped avoid delays.) ■

home," she explains.

Communication regarding the predicted discharge date and time is critical so that the entire team can execute the plan in a timely manner. For the ED, this timely discharge means a greater likelihood of a bed on the appropriate unit when it is needed and that any delay would be intentional and predictable and only to allow the right bed to be available.

In the absence of the ability to build new beds, Kiessling summarizes, timely discharge is a legitimate way to increase capacity in a hospital that operates with very few open beds at any given time.

In developing the predictive process, says Kiessling, "you have to build in the factor that you'll be wrong some percent of the time — anywhere from 20%-30% — not because you've not planned well, but because the child may not progress as well as you've planned." Still, she insists, "for any given unit, we can be right seven times out of 10." When planning for beds, then, you should look at your predictions and build in processes to account for the "unpredicted" beds that will be needed.

Where appropriate, you can write conditional discharge orders, i.e., when the patients meet these criteria, they can go home, she says. These criteria must be patient-specific, Kiessling emphasizes. Discharge medication orders and discharge summaries are among the things that can be done ahead of time, she says.

At this point, says Kiessling, some units are 80% correct in their predictions, while others are closer to 50%. While the discharge predictions are mainly done on the inpatient side, she notes, it still benefits the ED. "Oftentimes there are delays in the ED because of bed availability," she observes. "In order to set the stage for improvement, we had to have beds."

It's difficult to track time saved by this process, she says. "Some patients may meet the criteria at 2:30 in the morning," she explains. "Should we tell them to get up and leave because our numbers need to be good?"

At the same, says Kiessling, she began to look at how to predict admissions. "We have three kinds of admissions: scheduled, ED, and direct," she notes. "The trick is to know what's going on in the population you are looking at."

In January 2009, she says, a math formula was developed that allowed the ED to predict its admissions. The formula takes into consideration admissions from the ED "yesterday," "same day last week," "two weeks ago," "three weeks ago," and "four weeks ago," she says. These data are averaged. "We then look at trends for the last month in terms of percentage of ED visits admitted to the hospital and adjust accordingly," she notes. "It isn't an exact science yet, but we're working on it."

"We are within 90%-95% accuracy most of the time," Kiessling says. "Folks in my department and the ED clinical manager figured [the formula] out, and it's pretty good." ■

ED improves on already impressive wait times

QI method uncovers improvement opportunities

Before the implementation of a LEAN initiative in the ED at Good Samaritan Hospital in Kearney, NE, the average door-to-doc time was 28 minutes, and the average length of stay was 103 minutes — numbers that were nothing to sneeze at. Nonetheless, **Paul O'Connell**, RN, director of emergency services, wanted to see those numbers improve.

"One of our biggest challenges was that we were at capacity for our volume [about 15,000 patients a year] for the number of beds we had," O'Connell explains. "We used one bed in a trauma room, one in an ENT room, so we were really down to eight beds."

The only answer was to improve efficiency, he reasoned. Patient surveys told him that the most meaningful

Executive Summary

LEAN methodology, known for uncovering opportunities to improve by eliminating "wasteful" process steps, has helped the ED at Good Samaritan Hospital in Kearney, NE, make good patient flow numbers even better. The hospital went from a door-to-doc time of 28 minutes and length of stay (LOS) of 103 minutes to a door-to-doc time of 16 minutes and a LOS of 93 minutes. Here are some efficiencies that were implemented:

- standardized bedside carts and procedure carts that can be pulled into any room as needed;
- a manual-entry whiteboard with magnetized color-coded symbols to indicate patient status;
- a new documentation system that standardized the ED charting decreased the time required for documentation.

thing to them was seeing the physician. "So we wanted to further reduce door-to-doc time and with that, hopefully, get an improved length of stay, so we could free up beds for the next patient who might be waiting," says O'Connell.

And reduce it they did. Since October 2008, 70% of ED patients are being seen in under 16 minutes, and length of stay is down to 93 minutes. In addition, less than 1% of patients are leaving before treatment.

In addition, by creating a central supply room, the nurses' average miles walked per shift was reduced from 8 miles to 11 miles to 3 miles to 6 miles. This was considered an important goal because the number of Good Samaritan's RNs over 45 years old had grown from 39.2% to 40.3% from August 2008 to August 2009, and the hospital wanted to retain these "wisdom" workers. **(Staff involvement, a critical part of LEAN methodology, was an important factor in the success of this initiative. See the story, right.)**

Camil Saadi, the process improvement specialist who oversaw the initiative, says that with the centralized supply room, "the nurse could go to the central area and do one prep." Saadi had measured how far the nurses traveled to get supplies and remeasured after the new supply room was established to determine the amount of improvement.

Here are some of the other changes implemented as a result of the LEAN initiative:

• Implementation of a patient tracking system.

This system gave all of the emergency services staff and ancillary staff the ability to communicate about the status of tests and timing. Physicians and nurses know which patients need to be seen; if the tests have been ordered, given, and verified; and if a patient is ready for discharge. The staff use a manual-entry whiteboard with magnetized color-coded symbols.

Saadi adds that the communication board eliminates wasted time because nurses and doctors are able to see everything happening with their patients in one location.

• Relocation of the communication specialist and the communication equipment.

These resources for the emergency service ambulances and helicopters were moved out of the central nurses station to the adjoining room where patients are registered. This move reduced the noise in the ED and allows the communication specialist to focus on the transport and patient information.

• Implementation of new physician and nursing documentation.

Provided by Dallas-based T-system, it was acquired in March 2009 to standardize the ED charting, simplify the charting for nurses, and decrease the amount of time required for documentation. **(For additional information, see resource box, p. 8.)**

• The creation of standardized bedside carts and procedure carts.

With the bedside carts, nurses have the regularly used supplies they need right next to them, and the cupboards that took up valuable space were removed. The procedure carts are always stocked and can be pulled into any room as needed. These carts eliminated the need to have specialty rooms. The ENT chair was replaced with a chair/bed, which allowed this room to be used for more patients.

"Standardizing the rooms made everything so much more uniform, so wherever patients needed to go, everything would look the same to the staff," says O'Connell. "Before, we would get bottlenecks." The standardized laceration carts "could go anywhere," and the standardized supplies at bedside provided more resources at the point of care, he adds. ■

Staff drive changes in LEAN process

No one likes change, and ED managers often face a tough challenge when introducing new processes to their staff. This resistance was not the case, however, during a successful LEAN initiative at Good Samaritan Hospital in Kearney, NE, because of the very nature of LEAN methodology.

"The staff came up with the solutions — physicians, nurses, communications, the telemetry tech, the lab, radiology, even the switchboard," says **Paul O'Connell**,

Sources/Resources

For more information on improving ED processes using LEAN methodology, contact:

- **Paul O'Connell**, RN, Director of Emergency Services, Good Samaritan Hospital, Kearney, NE. Phone: (308) 865-7513. Fax: (308) 865-2375. E-mail: pauloconnell@catholichealth.net.
- **Camil Saadi**, Process Improvement Specialist, Good Samaritan Hospital. Phone: (308) 865-7100.

- **For additional information on documentation systems**, contact: T-System, 4020 McEwen Drive, Dallas, TX 75244. Phone: (800) 667-2482. Web: www.tsystem.com.

RN, director of emergency services. "The team drove the solution, not administration."

Camil Saadi, the process improvement specialist who oversaw the initiative, says, "The best part of LEAN is that you start with a blank sheet of paper and determine which areas you should focus on to give you the most benefits from an efficiency and capacity standpoint. A high percentage of patients we see in the ED are admitted, so that factored into why we chose the ED."

O'Connell made a significant contribution to the success of the initiative, Saadi adds. "It makes a big difference how well the director is involved and willing to put in the effort needed," he explains. "They have to be willing to think about the challenges the department faces, accept that there may be a better way of doing things, and be willing to work with the staff." ■

'Telepsych' program is a hit with patients, ED

Provider plans to begin outsourcing the service

While telemedicine has proven successful in several ED settings, some observers have long been skeptical that it could be applied to behavioral health. However, a program developed at the Princeton (NJ) HealthCare System has proven so successful that plans have been unveiled to offer it to other interested facilities.

"The program speaks for itself; wait times have been dramatically reduced," says **Ken Tedesco**, MA, director of external programs for Princeton House Behavioral Health, the behavioral health unit of Princeton HealthCare. Tedesco oversees the process. In the past, if patients arrived at the ED in the evening and there was no staff psychiatrist to see them, they could have waited until the morning to be seen, Tedesco says. Now, he says, the typical wait time is two or three hours.

Tedesco describes "wait time" as the time that it takes to move the patient through the ED, not the time that the patient waits before being seen or to see a psychiatrist. "So, while they 'wait,' they are also getting a nursing assessment, a crisis specialist assessment, and being seen by a medical doctor," he explains.

Kevin Sopko, MA, director of admissions at Princeton House Behavioral Health, says, "Being attended to quickly gives them something tangible, and that helps because during wait times there can be an elevation of anxiety for these patients." Sopko is responsible for the crisis clinicians in the ED of University Medical Center at Princeton. **(Flexibility also is a critical element of the program. See the story on p. 9.)**

When considering the program, there was some fear that patients would resent the fact that the process was being sped up, Sopko says. "But they actually prefer that; they want be seen as quickly as possible," he says. Once they become familiar with the technology, they like the fact that they can see the psychiatrist on the screen, Sopko says.

The process, which was introduced in mid-2007, is often set in motion during triage. "The patient may say something to the triage nurse that gets them designated as a patient with a safety risk. They may be suicidal, homicidal, or self-mutilative," Sopko explains. "They go through ED clearance, are examined by an ED doctor, and then our crisis clinicians will be called to the ED." The "crisis clinicians" are counselors or social workers — masters-prepared individuals with degrees in the psychological field, he says. There are at least two of them on any given shift, says Sopko.

Executive Summary

Princeton HealthCare System and its behavioral health unit, Princeton House Behavioral Health, have implemented a telepsychiatry program they consider so successful they are beginning to offer it to other hospitals and health systems. Here are some of the aspects of the program:

- Crisis clinicians are called to the ED if patients are considered to be a safety risk.
- If the patients give their consent, they are linked via computer and webcam to an off-site psychiatrist.
- Far from resenting what could be considered impersonal care, patients seem to be forming connections with their providers.

CLINICAL TIP

Explaining process keeps patients calm

While there were some concerns that a telepsych program would cause anxiety among the patients, that has not been the case with a program developed by Princeton (NJ) HealthCare System and its behavioral health unit, Princeton House Behavioral Health. Additionally, it shouldn't be a concern with any such program, says **Ken Tedesco**, MSW, director of external programs for Princeton House Behavioral Health.

"We have not seen any agitation from patients and only use the system for patients who consent to its use it," he notes. "When we explain the system, the patients are generally calm; but if medication interventions are needed to ease the patient, they are administered by the ED's RNs." ■

"After they interview the patient, they'll speak to the psychiatrist on call as well as the ED physician to keep them in the loop," he says. If a higher level of care is recommended by the crisis clinician — perhaps they had recommended admission but the patient refuses — the crisis clinician might call the psychiatrist to perform telepsychiatry. This process also can be used for commitment.

In addition, Sopko notes, the telepsychiatrist also might be called if a patient is otherwise ready for discharge but there are psychiatric concerns. Perhaps the patient might have been deemed unsafe prior to presenting to the ED.

Participation in the program is completely voluntary, Sopko emphasizes. "Written consent is required, and the clinician is with the patient the whole time to assist them with the device and to answer any questions," he explains.

Another concern that has proven unfounded was that the patients would perceive a physician speaking from a remote location to be cold and unsympathetic. "But it seems to have worked better than anticipated; the patients have connected with the psychiatrists," Sopko says. **(For more on how to keep this type of patient calm, see clinical tip, above.)** The staff "has been quite in favor of it being used," he adds. ■

Flexibility is hallmark of telepsych program

A successful telepsychiatry program at the Princeton (NJ) HealthCare System owes part of its success to its flexibility, says **Ken Tedesco**, MSW, director of external programs for Princeton House Behavioral Health, the behavioral health unit of Princeton HealthCare. Tedesco oversees the process.

For example, there are no rigid rules concerning the configuration of equipment, he says. "The nice thing about equipment is that it has become so high tech and readily available. For setup, all you require is a viewing screen and a link to the Internet," says Tedesco. So, for example, the ED user can employ a computer or a 42-inch, flat-panel TV screen, along with a webcam. "One of the more interesting things we're looking at that would be real helpful around the state is putting a smaller version on a little cart on wheels so you can bring it bedside and further speed up the psychiatric screening process," says Tedesco.

Princeton has just launched a service for facilities outside the system. Here, staffing flexibility, which already has benefitted the system, can come in handy.

"The psychiatrists are the staff of the Princeton Healthcare System," Tedesco explains. "We engage our psychiatrists with the staff of the host facility to assess the patient and move the process along as quickly as possible in the best possible way." There are designated Princeton staff members for telepsychiatry, he adds, "and we may have additional people who float."

If there is a contract with other facilities, he adds, additional psychiatrists might be designated. "We can manage the process in two different ways," Tedesco explains. "We have a Princeton House unit through which the psychiatrist can remotely access the facility, but if they are unable to be there, we have a physician available who can connect remotely from a home office." ■

Sources

For more information on telepsychiatry, contact:

- **Kevin Sopko**, MA, Director of Admissions, Princeton House Behavioral Health, Princeton, NJ. Phone: (609) 497-4000.
- **Ken Tedesco**, MSW, Director of External Programs, Princeton House Behavioral Health. Phone: (609) 712-0731.

RRTs are involved in STEMI response

(Editor's note: This is the second part of a two-part series on recent reaccreditation efforts made by the staff of the chest pain center at Oregon Health & Science University Hospital in Portland. In the first installment last month, the staff discussed the STEMI alert training procedures involved. These procedures not only involve the triage nurse, but the entire staff, including the valets. This month, we look at how the staff brought the hospital rapid response team into the process, and how the acquisition of atomic clocks enabled the ED and outside resources to accurately track their response times.)

During the recent reaccreditation process for the Oregon Health & Science University (OHSU) Hospital's Chest Pain Center, **Mary Spiering**, RN, MN, CNS, clinical nurse specialist for the cardiac service line, realized that "we really needed someone else" during ST-segment elevation myocardial infarction (STEMI) activation. Accordingly, Spiering got the hospital rapid response team involved.

"Now, during every STEMI activation, we have a respiratory therapist, cath lab interventional doctors, and the administrator on call," Spiering explains. "We trained them to not only pick up the patient, but to slap on the defibrillator. We found there were times they got there before the nurse could come or before the nurse got to the Pyxis machine."

Accordingly, she says, the rapid response team is now provided STEMI meds packets, which include aspirin, heparin, and other medications.

As another part of the reaccreditation process, about 35 atomic clocks were ordered and placed in the ED. "We wanted to make sure they were in every single room," explains Spiering. "When the clock starts for door-to-balloon time, we need *precision* time so we understand exactly when the patient arrived, when we did the EKG, and so on. *Everything* should all be timed on the same clock."

In the past, she notes, nurses would write down these events, and the timelines would sometimes conflict. "Time is always an issue," says Spiering, adding that OHSU's rural partner facilities also now have atomic clocks in their EDs. The clocks cost $123 each, says Spiering. ■

Source

For more information on managing chest pain patients, contact:

- **Mary Spiering**, RN, MN, CNS, Clinical Nurse Specialist, Cardiac Service Line, Oregon Health & Science University Hospital, Portland. Phone: (503) 494-8311.

Emergency departments post wait times on the web

Marketing pushes idea, but ED had to approve

(Editor's note: This is the first part of a two-part series on posting wait times online. In this story, we tell you how two EDs prepared to add this service. In next month's issue, we'll tell you how the EDs used a test web site to help the staff become acclimated to the new system.)

Several months ago, the two EDs of Sacred Heart Medical Center in Eugene, OR, began posting their waiting times on their home page (www.peacehealth.org/shmc). There was a good deal of hesitation at first, say the ED leaders. However, patient satisfaction has risen from 96% to 100%, and the "peaks and valleys" of patient flow seem to have leveled out, they say.

"It was initiated by our marketing department," recalls **Joy Cresci**, RN, assistant administrator of emergency and critical care for Sacred Heart, which has EDs in its RiverBend facility in Springfield and at University District in Eugene. "They found out that Scottsdale [AZ] Health System have their times on their web site." As it turned out, one of Sacred Heart's hospitalists had come from that system and said that it had been helpful, she says.

The move made sense to the marketing department

Executive Summary

The two EDs of Sacred Heart Medical Center in Oregon have been posting their wait times online for several months now, but the introduction of this service didn't come without a great deal of preparation. For example:

- ED charge nurses at facilities that already had posted wait times online were contacted to see if there had been any problems.
- A communitywide education effort was put in place to let potential patients know what was coming.

Sources

For more information on posting waiting times online, contact:

- **Joy Cresci**, RN, Assistant Administrator of Emergency and Critical Care; **Gary Young**, MD, ED Medical Director, Sacred Heart Medical Center, Eugene, OR. Phone: (541) 686-7300.

from a competitive standpoint. Rival McKenzie-Willamette Medical Center in Springfield had been boasting about its short ED wait times on billboards and on its web site for months. Initially, however, there was lot of pushback in the ED, especially from charge nurses. "They felt we would be setting up false expectations," explains Cresci, who ultimately led the effort to post the ED wait times.

Gary Young, MD, the ED medical director, says, "It's something we struggle with all the time. There were times recently when we had record numbers of patients coming to the EDs, even though many had H1N1 and were able to go home."

Hospital administration left the decision up to the ED, and the department leadership began meeting to discuss the idea. "The competition of the other hospital changed many peoples' perspectives," says Cresci, "So I called the hospitals in Scottsdale to talk to their ED charge nurses and see if any of the issues raised by our charge nurses had materialized, and they said they hadn't."

The other reason the move made sense, says Cresci, is that one of the Sacred Heart hospitals had been open only for about a year, and the newer hospital was being overwhelmed with patients. The older facility had more capacity and could have taken more patients.

"Part of what we did to pave the way was to educate the community," adds Cresci. "We let them know that both EDs were staffed by the same doctors and the same level ED nurses." When they "went live" in September 2009, she adds, news releases were issued and interviews were conducted on local TV stations.

Young says, "We've been getting the word out through the media and mailings for more than a year, and it's still hard to make sure everyone understands what's happened with the two EDs. It will probably take another year or two." ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity with the **March** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CNE/CME *questions*

19. According to Pamela Kiessling, RN, MSN, when creating a formula for predicting discharges, it's important to plug in a "fudge factor" to allow for patients who do not progress as rapidly as you had anticipated. What is that "fudge factor"?

A. 10%-20%
B. 15%-25%
C. 20%-30%
D. 25%-35%

20. Under the new rapid evaluation unit model being used by the ED at Palisades Medical Center, a patient may be triaged by:

A. a nurse.
B. a physician's assistant.
C. a physician.
D. Any of the above

COMING IN FUTURE MONTHS

■ Nurses given ownership of follow-up and callbacks

■ TJC adds heart attack, heart failure, and pneumonia performance data

■ Setting worthwhile goals in the emergency department

■ How do highest grossing EDs optimize outpatient charges?

21. According to Paul O'Connell, RN, patients responding to a satisfaction survey said the most important factor to them was:
A. total length of stay.
B. how quickly they were seen by a physician.
C. how quickly they were seen by a nurse.
D. believing their physician cared about them.

22. According to Kevin Sopko, MA, the "crisis clinicians" used in the new telepsychiatry program are:
A. counselors or social workers.
B. psychiatrists.
C. psychologists.
D. nurse practitioners.

23. According to Mary Spiering, RN, MN, CNS, which members of the rapid response team are on call during every STEMI activation?
A. A respiratory therapist.
B. Catheter lab interventional physicians.
C. An administrator.
D. All of the above

24. According to Joy Cresci, RN, the ED charge nurses expressed initial concerns about posting the department's waiting times online. What was their main objection?
A. The ED would become overcrowded.
B. The process would establish false expectations.
C. Posting wait times would take them away from their patients.
D. Other EDs with shorter wait times would post those times online.

CNE/CME answers

19. C; 20. D; 21. B; 22. A; 23. D; 24. B.

2009 SALARY SURVEY RESULTS

ED Management®

Best Practices – Patient Flow – Federal Regulations – Accreditation

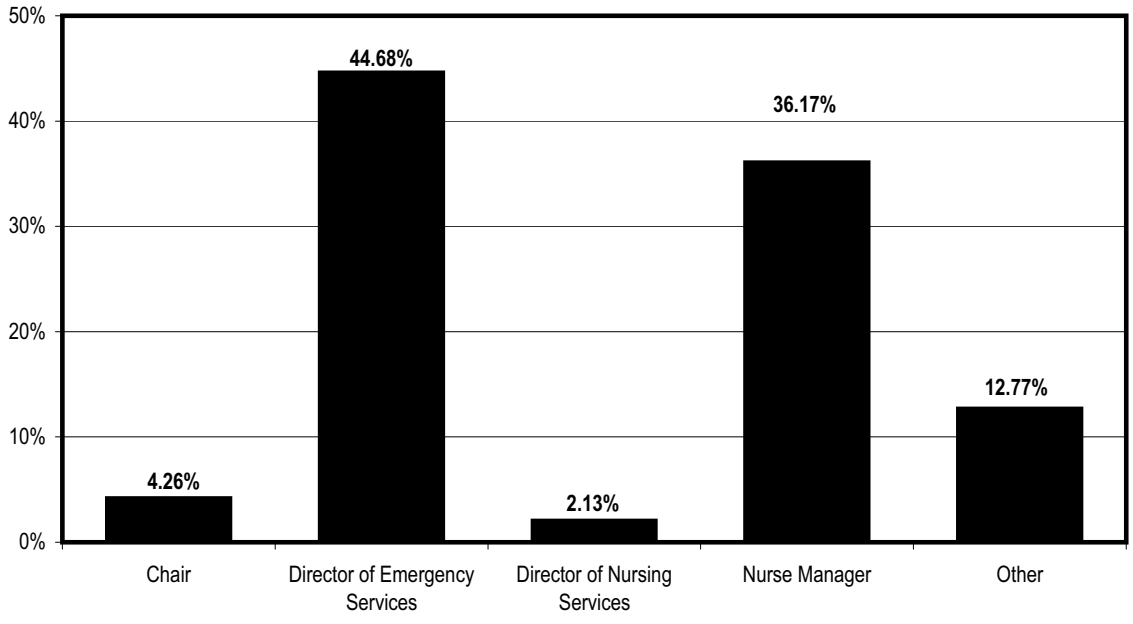
ED manager salaries remain stagnant — experts say doctors faring better than nurses

Generally when we review our annual *ED Management* Salary Survey for defining trends, we see patterns emerging by reviewing the results in several categories. And while we still went through that process this year, even a quick glance at the results of the 2009 *ED Management* Salary Survey showed that one statistic jumped off the page.

In the 2008 *EDM* Salary Survey, 8.2% of the respondents indicated no change in their salary; in the 2009 *EDM* Salary Survey, that number more than quadrupled to 36.96%.

Why are so many more hospitals holding the line when it comes to salaries? Observers say it's a combination of growing financial pressures and a favorable supply-demand ratio, especially when it comes to nurses. "The salary numbers in the survey are definitely in line with what's happening," says **Diana S. Contino**, RN, MBA, FAEN, senior manager of health care with Deloitte Consulting in Los Angeles. "We're continuing to see cost pressures on hospitals and health systems." These pressures, she notes, are coming from the increases in labor and capital expenditures needed to meet the American Recovery and Reinvestment Act of 2009 (ARRA); the related HITECH Act of 2009, which includes additional Health Insurance Portability and Accountability Act (HIPAA) requirements; and the

What is Your Current Title?



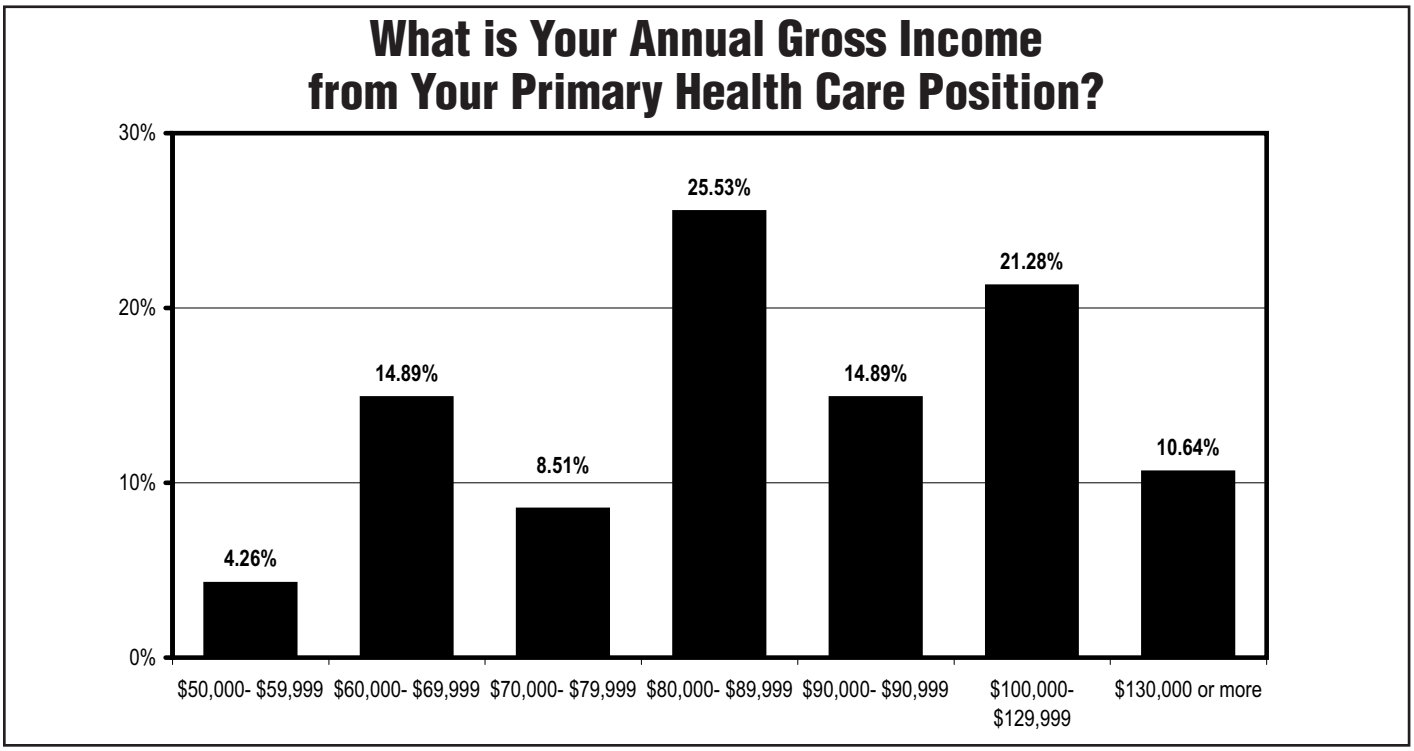
general tightening credit market.

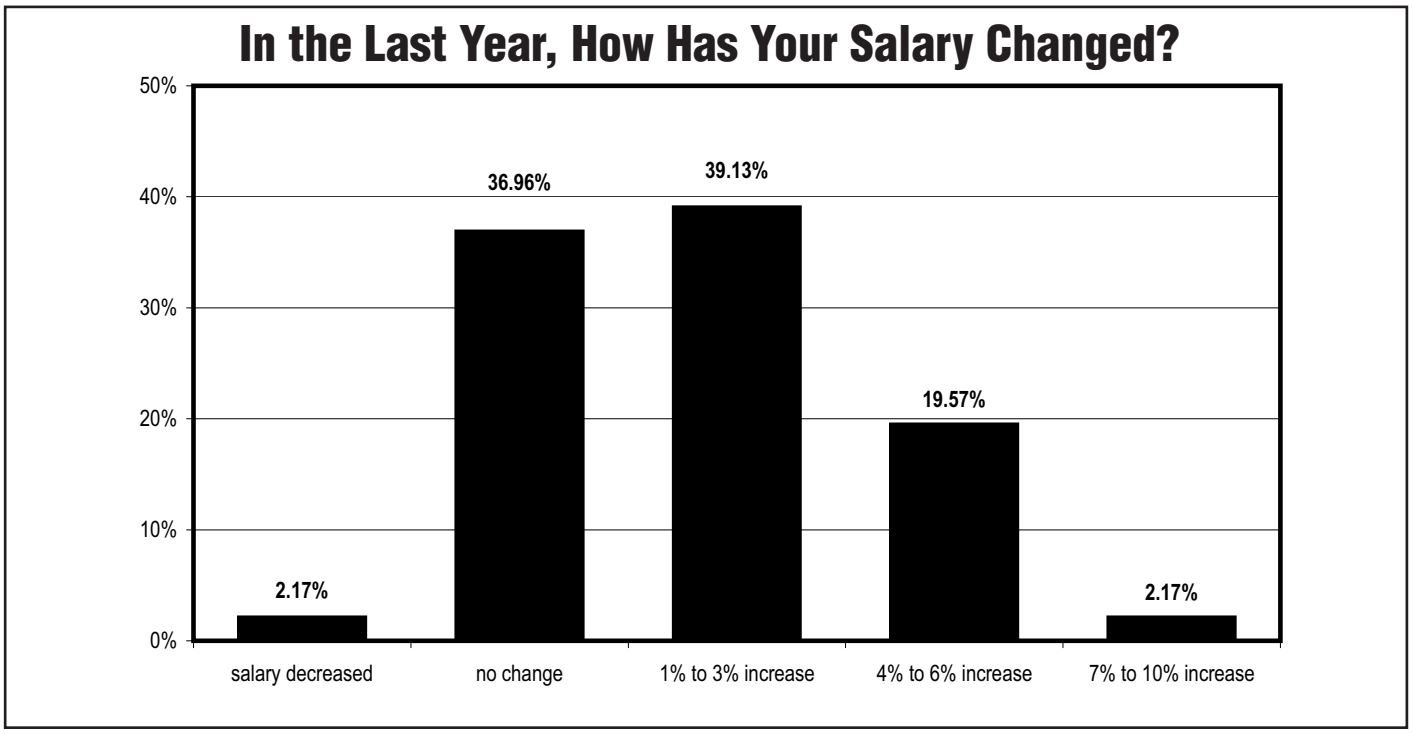
From the hospital's perspective, Contino summarizes, the supply has increased and demand has decreased. "At the same time, profit margins are stagnant or have declined," she adds.

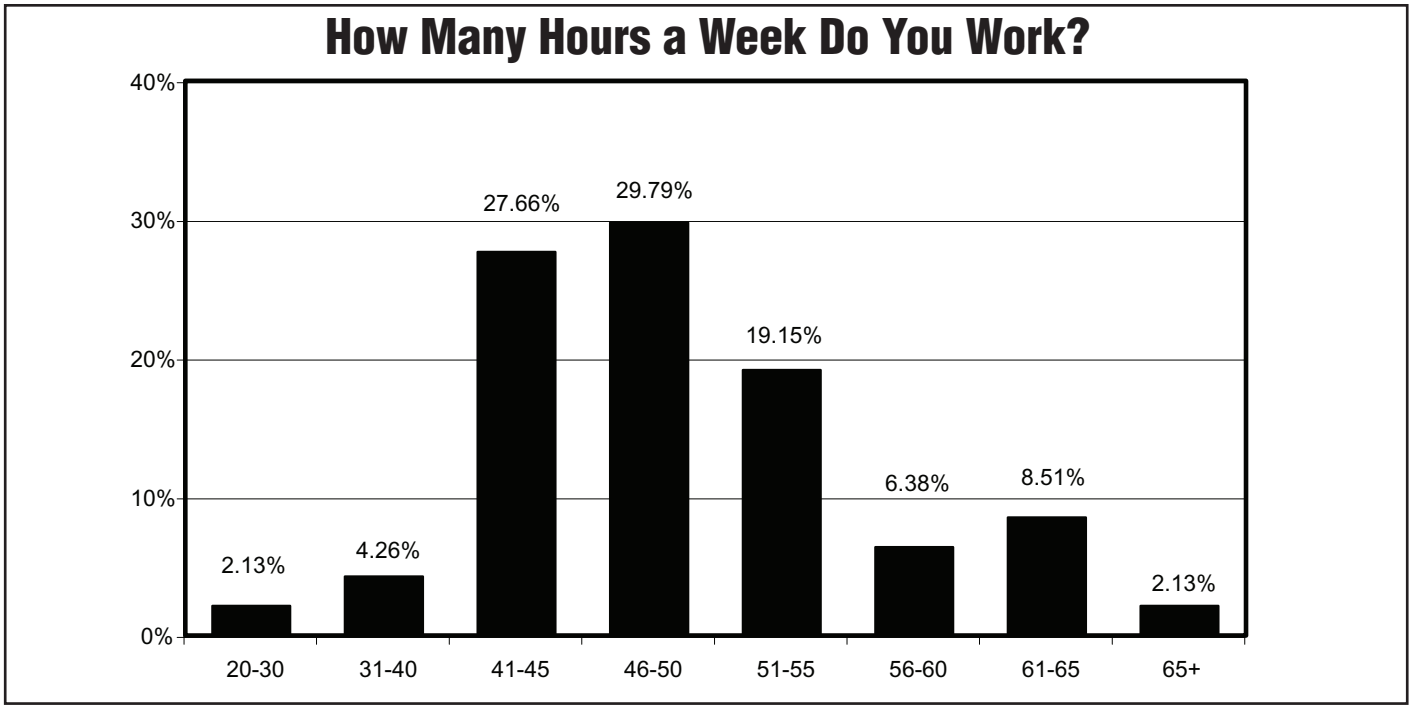
"We're also seeing many clients significantly increase their expenditures for EMR [electronic medical record] software, implementation, support, and data security." These combined efforts, she says, can cost hundreds of thousands of dollars.

"That being said, the majority of nurse managers are not seeing a significant increase in compensation," Contino says. This stagnant salary is very typical in the current job market, she explains. "The unemployment rates are so high, and many nurses have gone back to work because spouses or significant others have lost their jobs," she observes. "Many of these nurses were working per diem or part-time hours and have accepted full-time positions. Others who weren't working have gone back to part- or full-time positions."

Trends among ED physicians and managers are similar, says **Michael D. Bishop**, MD, president and CEO







of Unity Physician Group, a Bloomington, IN, firm that staffs hospital EDs in Indiana and Kentucky and owns and operates urgent care centers in Indiana. "I know of several [ED physician] groups that have taken 15%-20% decreases," he notes. "If you're a relatively small group — one, two, or three hospitals — and you are in the Midwest, then there's a reasonable possibility there have been some decreases."

In areas where there are shortages of qualified applicants, however, ED physician managers can pressure hospitals, especially in the current financial environment. "The number of indigent, uninsured, underinsured, or ED copays have gone up, or the number of Medicaid patients has gone up and states can't pay as much," Bishop notes. "The ED may have once been viable on a fee-for-service basis, but not anymore, and the doctors can go to the hospital and say, 'You either subsidize us, employ us and our group, or we have to go someplace else.'" What the hospital figures our real quickly, he says, is that it doesn't matter whether they deal with this group or another group. "The market is the market." Bishop asserts.

Numbers are discouraging

The rest of the 2009 *EDM* Salary Survey results round out the bleak picture. The number of respondents who saw salary decreases actually dropped slightly, from 3.28% in 2008 to 2.15% in 2009. However, in the rest of the categories, there were decreases across the board. Those receiving 1%-3% increases dropped from 49.18% to 39.13%; those receiving increases of 4%-6% dropped from 27.87% to 19.57%; and those lucky few receiving 7%-10% increases dropped from 6.56% to 2.17%.

The number of managers in the highest income levels also dropped when compared with the 2008 *EDM* Salary Survey results. For example, in 2008, 18.03% were in the $90,000-$99,999 range, compared with 14.89% who responded to the current survey. Those between $100,000 and $129,000 also fell, from 27.87% to 21.28%. The number of respondents making $130,000 fell dramatically, from 21.31% to 10.64%. While those making between $70,000 and $79,999 also decreased (11.48% to 8.51%), those making $60,000 to $69,999 increased, from 3.28% to 14.89%.

For the 2009 report, 580 surveys were disseminated. There were 47 responses, for a response rate of 8.1%.

'There appears to be more pressure on nurses' salaries than on emergency physician salaries," notes Contino. "Some of this is related to supply vs. demand."

There are some "difficult-to-recruit" geographical areas that continue to see shortages of emergency physicians, she observes. "This has continued to keep pressure on hospital subsidies — administrative stipends — and physician salaries," Contino explains.

In addition, she says, "There are not as many open positions — both staff and manager — working for temporary staffing firms. There's definitely more competition for those positions." The firms that place interim directors have seen declines in requests, she adds. "Many may not hire an interim director when they can fill the position with a permanent employee," notes Contino.

However, there often is more than meets the eye when it comes to compensation for physician managers, says Bishop. "It's always difficult when you talk to emergency physicians and ask them if they took a cut," he notes.

"Their 'W-2s' may have increased, but instead of working 16 shifts a month they are now at 18 or 20; so on an hourly or daily basis, they may actually be making less money."

"Efficiency" is the watchword in today's economy, Bishop says. "Let's say you have a 20-physician department and they make $100 an hour, and you are going to lose five physicians," he says. "Those that are left may decide they all just want to work harder instead of replacing the five physicians. If they have less coverage per shift to maintain their income, haven't they really taken a pay cut?

Circumstances will not improve any time soon, Contino says. "I don't see a trend of hospitals raising salaries for nurse managers; most likely they will stay the same, and in some cases they will decline," she predicts. In fact, Contino adds, "There are some hospitals and health systems that have already reduced salaries or deferred raises. For example, many of the University of California hospital employees have experienced reductions."

If the economy remains stagnant and cost pressures continue, she says, organizations will look for ways to increase productivity — automate processes and increase self-service options — and decrease labor costs.

This increased emphasis on productivity, along with the shifting realities of the ED environment, add up to even greater pressure for ED managers, says **Mike Williams**, MPA/HSA, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services.

"There is no ability to control your work, and there are many variables and risks such as EMTALA," says Williams, referring to the Emergency Medical Treatment and Labor Act. And circumstances were particularly difficult recently with the H1N1 flu, he says. "It just provides a much more difficult environment, because some facilities are not willing to put systems in place to help manage these peak loads," he says. Most hospitals want to take the position of "toughing it out" rather than being prepared in advance, he says.

"Part of the problem is that they are not filling those [management] positions with experienced people, but rather organizationally growing people into those positions from assistant directors and charge nurses," Williams explains. "That's not bad in and of itself, but it takes a little foresight. You can't just appoint somebody."

To prepare these people for promotion, he explains, "you need mentoring services, or parallel processes that will enable these individuals to experience difficult situations and to see their reactions — which skills they bring to the table — and offer advice on how the department would ideally be managed." Growing organizationally is a relatively new concept that has been reached by some of his clients who were having difficulty recruiting new talent, Williams says.

Bishop says, "Managers have to do so much more. There's a tremendous amount of work for physician directors of EDs or ED group directors." That work ranges from boarding issues to H1N1, he says. "Flu has the potential to put a whole bunch of sick people in the ED to drive up demand, while at the same time you're trying to get lab work back, get imaging results back, get people moved out of the department, and manage those people who may be potentially infectious," Bishop says.

Williams agrees. "The biggest and largest new trend is responsibility for major emergencies," he says. "Almost every community has a plan for pandemics and catastrophic terror events. There's a fair amount of federal money being spent and it's trickling down, but it's spent mostly on equipment and planning at the community level." For the most part, Williams says, the ED manager must collaborate with the county or state, or the hospital's own "disaster person" — who already had a full-time job. "So, again there are additional burdens," he says.

You still need to perform

Despite the stagnation in salaries, hospitals continue to pressure ED managers to perform, and they continue to link compensation to that performance.

"Nurse managers may be paid a little less, but they will still have to assure their departments and employers that they are meeting performance targets," Contino says. "There won't be any decrease in performance improvement expectations in customer service, satisfaction, and quality measures." As with much of health care and society in general, nurse managers are being asked to do a lot more for less money, and treat higher-acuity patients, she says.

In fact, notes Williams, better performance in those areas will not only help managers earn bonuses, but they actually will help hospitals attract more and better employees. "Hospitals have finally got it. The successful mixture for staff and managers is customer service, employee service, and throughput strategies, and innovators in those areas could make the campus much more attractive," he says. "One of the hottest things in hospitals today is achieving magnet status. It takes in excess of a year, and involves the entire hospital."

Where there is a limited pool of managers and they have choices, especially in urban areas, Williams says, "this is another little 'carrot' that says, 'We are better than the others. We have better throughput and staff education, we're sensitive to customers so there are fewer problems, and we're willing to support you in your role as manager.'" In some cases, say observers, those conditions can mean more than money. ■

AHC Media LLC

AHC Media's Message to Subscribers about Copyright Law

Your newsletter is a copyrighted publication. It is protected under federal copyright law.

It is against the law to reproduce your newsletter in any form without the written consent of AHC Media's publisher. Prohibited under copyright law is:

- making "extra" copies of our publication for distribution in your office;
- posting newsletter articles on your facility or practice web site;
- downloading material to an electronic network;
- photocopying, e-mailing, or faxing newsletter articles.

Site licenses, which allow you to e-mail, fax, photocopy, or post electronic versions of your newsletter and allow additional users to access the newsletter online, are available for facilities or companies seeking wider distribution of your newsletter.

High-quality reprints of articles also are available at reasonable prices.

To get information about site license or multiple copy arrangements, contact Tria Kreutzer at (800) 688-2421, ext. 5482 (tria.kreutzer@ahcmedia.com); or for reprints, contact Steve Vance at (800) 688-2421, ext. 5511 (stephen.vance@ahcmedia.com).

Thank you for your cooperation,

Donald R. Johnston
Senior Vice President/Group Publisher
AHC Media LLC

N #4005

3525 Piedmont Road NE
Building Six, Suite 400
Atlanta, Georgia 30305-1515
Tel (404) 262-7436
Fax (404) 262-7837
www.ahcmedia.com