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Slash wait times, maximize resources with novel ED protocol

While emergency department (ED) volume is always going to be somewhat unpredictable, ED operations at Ochsner Medical Center in New Orleans, LA, used to hum along so optimally that there was no reason to rethink the way things were done. "We had 99% patient satisfaction for 15 straight quarters, and our door-to-doc time was like 20 minutes. Life was pretty smooth," recalls **Joseph Guarisco**, MD, chairman of the department of emergency medicine at Ochsner Health System.

But everything changed in 2006 when hurricane Katrina decimated the city, along with 77% of the region's health care resources. "We were one of the few hospitals open, so our volume nearly doubled, and it just destroyed the way we practiced," stresses Guarisco, explaining that all of a sudden, the typical day in the Ochsner ED involved long lines, people waiting, and resource constraints. Patient satisfaction plunged into the 20th percentile.

Guarisco knew he needed to find a way to move patients through the system more efficiently without utilizing more resources, so he reengineered ED operations in a way that preserves precious beds only for the sickest patients and maximizes the use of treatment rooms and waiting areas so that patients who are waiting to undergo tests or procedures aren't keeping new patients from being seen.

EXECUTIVE SUMMARY

When a sudden increase in volume overwhelmed Ochsner Medical Center in New Orleans, LA, in the wake of hurricane Katrina, ED administrators created QTrack, a new ED protocol that effectively doubled the capacity of the ED by taking full advantage of waiting-room space while preserving beds for only the sickest patients. The approach requires firm policies and procedures and continual provider reinforcement, but the results are dramatic.

- Patient satisfaction has risen from the 20th to above the 90th percentile.
- Average door-to-doc times have been slashed from hours to about 33 minutes.
- The LWBS rate is below 1% at facilities where QTrack has been implemented.

It has taken years to fine-tune the process, dubbed QTrack, and obtaining provider buy-in is a never-ending affair as new clinical staff are constantly rotating through the system, says Guarisco, but the results are impressive. Patient satisfaction is now back above the 90th percentile, the left-without-being-seen (LWBS) rate is below 1%, and the average door-to-doc time is in the 30-minute range.

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Preserve beds for sickest patients

Guarsico's goal in developing the QTrack approach was to weed inefficiencies out of the system. For example, he felt that the hand-offs from triage to a fast track area involved wasted time and energy, so he re-purposed the fast track function and moved it to the front of the ED so that it is now situated directly behind triage. This eliminates the needless transporting of patients to a more distant area. Secondly, while triage nurses used to have to determine whether a patient was too sick for fast track, the only question they have to answer now is whether a patient requires a bed.

"The bottom-line rule is that patients who don't need a bed don't get a bed. If they need a workup, we can do that in the ambulatory environment just like most people do in the outpatient setting, but they don't get a bed," explains Guarisco. "We have put this superhighway, front-end cueing system in place that preserves beds in the back … so that we preserve our most valued resource, which is the bed on the acute side."

Instead of being placed in beds, patients who are awaiting tests or procedures are typically sent back to the waiting room where there are chairs and recliners they can use, depending on their level of need. This has effectively doubled the size of the ED, says Guarisco. "We put an LPN in the waiting room who does nothing but monitor patients and make sure that they are kept informed," he says. "She's a safety net … and I think patients like having a clinical person out there in the waiting room with them to answer questions, so it has been a win/win for everyone."

Match staffing to demand

A second key component of QTrack involves making sure that you resource demand, says Guarisco. "We have as many intake rooms as it takes to see patients on arrival," he says. "We don't always succeed because you can exhaust any system, but we've had significant improvements by getting rid of fast track, implementing an in-line process, and putting rules and resources in place. The end result is that we don't run out of beds most of the time."

Getting the staffing just right to optimally manage QTrack took time to finesse, acknowledges Guarisco. "We actually had some attrition, and then we replaced those [physicians] with mid-level providers, and we replaced some of our RNs with LPNs, so that

allowed us to resource the demand at lower cost," he says. "We added people, but we didn't add cost."

Further, once QTrack went online, it was clear that adjustments needed to be made in the staffing levels so that they correlated better with patient demand. "We took the same personnel and the same volume, and deployed them in a different fashion so we did not add people; we just resourced them differently. The result was that right away patients were seen earlier, so the later shifts were over-staffed," says Guarisco. "So we took staff from the later shifts and moved them up earlier."

The core principles behind QTrack are not clinical at all, but rather stem from engineering theory, lean thinking, and demand and capacity matching, explains **David Eitel**, MD, MBA, a co-inventor of ESI Triage, and co-author of *Optimizing Emergency Department Throughput: Operations Management Solutions for Health Care Decision Makers* (Productivity Press, 2009). "It's a way of thinking that hasn't come to most of health care just yet," he says.

Further, while Eitel admires the approach that he has reviewed in person, he stresses that it is not necessarily going to work in all settings. "You need to have a volume that can support at least two physician-level providers working at the same time," he says. "And people have to be willing to work together in teams, although I don't find that to be much of a problem in emergency medicine because that is what we try to do." ***(See: Be prepared to customize when implementing a new ED protocol, p. 52.)***

Eitel explains that approaches like QTrack are focused on the delivery side of things, as well as making sure people get the right cluster of resources they need in a series of steps that eliminates all the waiting that typically goes on in most EDs. It's a positive approach, says Eitel, but he cautions ED managers who are interested in implementing this type of system to make sure all personnel understand their roles in the new system before going live. "Learn your roles altogether before the switch goes on so there will be no chaos," he says.

Put teeth in the process

Further, you can't just implement a process like QTrack and assume all the changes will stick, stresses **Armando Hevia**, MD, the director of emergency medicine at Ochsner Medical Center. He explains that administrators realized relatively quickly that they needed to put more teeth in the process. "Once we launched QTrack, everyone eventually drifted to old patterns or old behaviors, so it was really a matter of maintaining a set of rules that would allow the process to continue to work," he says.

For example, to keep patients moving through the system, one iron-clad rule is that a patient cannot remain in an intake room when his or her initial assessment has been completed, says Hevia. "Once the physician steps out of that room, it must be made available again to another patient," he says. Patients can be moved from the intake room to a procedure room, a treatment room, the waiting room, or they can be discharged, but they must be moved on, adds Hevia. ***(Also see Management Tip on the importance of including patients in the communications loop, p. 53.)***

Another policy involves what Hevia refers to as the "rule of two." This actually pertains to a series of rules that are easily remembered because of their relationship to the number "two." For example:

- Patients cannot receive more than two bags of fluid or two doses of medicine while remaining in a recliner;
- Patients cannot remain in a recliner for more than two hours; and
- Patients must be able to use both feet to be placed in a recliner.

"These are just policies and procedures that prevent the system from bogging down," explains Hevia. However, he emphasizes that while they may sound simple enough to implement, the change was actually quite difficult.

"The ED mentality was that when a patient comes to a room, one nurse owns that patient and treats that patient throughout the course of his stay," says Hevia. "In this new situation, one nurse focuses on one particular task, and doesn't get torn away to do three other things with three other patients."

While the QTrack approach enables nurses to focus their efforts in one general area, it nonetheless requires an alteration in the way people have always done things, and that can create stress, says Hevia. However, he adds that the benefits of the approach more than counteract the difficulties inherent in changing old patterns and behaviors.

"The stress that is relieved on the ED [physician and nursing staff] when you don't have three or four-hour wait times is enormous," notes Hevia. "There are a lot of benefits to increasing your power and having a better workflow."

While there is likely to be continued tweaking of QTrack, Guarisco maintains the health system has a mature process now, and the approach has been implemented in six Ochsner hospitals. "It has worked out beautifully. We are seeing more patients

faster and at lower cost. And that is where health care is going," he says. ■

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Be prepared to customize when implementing a new ED protocol

While much can be learned from other institutions, ED managers interested in implementing a new patient-flow process will always need to take their own size, culture, and unique circumstances into account in customizing a process that will work optimally in their work settings, according to **Julian Springler Jr.**, RN, the unit director of the ED at Ochsner Baptist Medical Center in New Orleans.

Springler understands the issue firsthand. When he was at Oshner Baptist Medical Center, he took charge of implementing QTrack, an ED protocol that was developed at Ochsner Medical Center, a much larger sister facility. He had to basically start from scratch to figure out how many intake rooms he needed to allocate for the system to work optimally in his 12-bed ED and how to adjust staffing. "I had worked collaterally with QTrack and really believed in the system and the philosophy a great deal … but how it works in a larger setting does not really equate to how you would do it on a smaller setting," says Springler.

However, despite some significant initial pushback from both physicians and nurses, Springler was able to bring QTrack online at the hospital in the space of six weeks. "I figured we would go through some pitfalls for a little while, but within a month we had significantly increased our patient satisfaction, our discharge LOS went down by about 40 minutes, and then we also decreased door-to-doc time by 11 minutes," he says. "However, we are still going through revisions. I view it as an evolving, rather than a static process."

Critical to the success of the implementation were weeks of actively engaging staff to get their input on the new process, as well as plenty of staff education on how QTrack works, explains Springler. "We met with a lot of the staff members to solicit their ideas, but we also said that this is going to happen, let's make it work for us," he says, noting that he was eager to hear about any concerns staff had so that these could be addressed before going live with new protocol in December of 2010.

One problem that came to light was how much delays in other hospital departments, such as imaging, for example, can cause delays in the ED. For this reason, Springler stresses that it is critical to consult the administrators of these other areas when you plan to implement a new system. "Make sure you involve imaging, med-surge staff, telemetry, and the ICU, and explain what is going to happen and how will impact their patients," he says. "They need to know that they may get called to do a CT scan on someone who is sitting in the lobby with their clothes on because the imaging staff may need to come with an area where they can get someone into a gown."

Springler emphasizes that there were no new costs associated with the implementation, although the education piece takes time. "A lot of pre-work goes into this. It is not something that you can just snap your fingers and pull the trigger on," he says. "We worked on this for about a month and a half before we went live."

While the implementation required significant effort, the impact of the new approach was apparent quickly. Patient satisfaction, which had hovered in the 30% to 50% range in the months leading up to the implementation, shot up to 90%, and the average door-to-doc time went from 38 minutes to 27 minutes within one month. Further, daily ED volume has increased from about 55 patients per day to 63 patients per day at press time. ■

SOURCES

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Management Tip

When implementing a new process, make sure patients are brought into the loop

Keep in mind that when you re-engineer your patient-flow process, clinicians aren't the only ones who may feel stressed and concerned. Patients who are used to the way things used to be done are likely to have concerns as well — especially if they are experiencing a true medical emergency. **Joseph Guarisco**, MD, chairman of the department of emergency medicine in the Ochsner Health System in New Orleans, LA, advises colleagues to have a communications plan in place for patients whenever you go live with any new system that impacts their ED experience.

That's what Guarisco did when implementing QTrack, a new approach to the health system's patient flow process that involves sending many patients back to the waiting area while awaiting tests and procedures. He made sure that staff were ready to explain the new approach in a positive way.

"We scripted it in the patients' minds as a value-add," says Guarisco, noting that patients received the message that they were being sent back to the waiting area so that they would have the freedom to move around, go to the cafeteria, or watch television while awaiting the next step in their care. "We also created a brochure that we give to patients that explains the process," he says.

The result is that there have been few complaints about the new process, and patient satisfaction is on the rise. "It's just a matter of how you manage the process and communicate it to patients," says Guarisco. ■

ED navigators connect patients to better venues of care

Long-term goal: Change consumer behavior

As reform helps more Americans gain access to health coverage, experts predict that the nation's EDs will be bulging at the seams. This could clearly complicate efforts to rein in costs, as ED visits are much more expensive than care delivered through physician office visits or urgent-care centers. However, to address this problem before it escalates, Albuquerque, NM-based Presbyterian Healthcare Services (PHS), an integrated system including eight hospitals, a health plan, and a growing medical group, is using what it calls ED navigators to re-direct patients with non-emergency issues to the most appropriate care setting for their needs.

In the model, providers determine whether a patient should be navigated to a less-acute setting during the medical screening exam. In these cases, an ED navigator will schedule the patient to be seen by another provider within 12 to 24 hours, explains **Mark Stern**, MD, medical director, medical management, and endcare coordination and an emergency medicine physician at PHS. "Most, if not all, emergency physicians will say there is a better venue of care for these types of patients in which they will receive better care at a cheaper cost," he says. "It usually doesn't work that way. That's one of the reasons why we began doing this in the emergency department."

Fully launched on July 26, 2010, the ED navigator

EXECUTIVE SUMMARY

Presbyterian Healthcare Services (PHS) in Albuquerque, NM, has implemented an ED navigator program designed to redirect patients with non-emergent cases to more appropriate and less expensive venues of care. Providers determine whether patients should be navigated during the medical screening exam, and then personnel with customer-service backgrounds set up appointments for these patients to be seen within 12 to 24 hours. The long-term goal of the program is to educate consumers to seek care for non-emergent conditions in the most appropriate setting to begin with, and early indications are that the approach is working.

- The program is consistently navigating 12% to 14% of ED patients to less acute settings, but administrators believe there is more opportunity yet to be realized.
- Only 3% of patients who have been navigated have returned to the ED for non-emergent care, and if this trend continues, administrators anticipate the program will produce cost reductions in the next three to six months.
- The biggest hurdle in implementing an ED navigator program is obtaining buy-in from emergency physicians because they're the ones who determine whether a patient will be navigated.

program is now consistently navigating 12% to 14% of the ED volume to a more appropriate setting of care, but program developers believe there is much more opportunity yet to be realized. Further, they are particularly enthusiastic about the fact that only 3% of navigated patients have returned to the ED at a later date. This suggests navigated patients have been connected with a more appropriate care setting that they can turn to for their non-emergency needs, but it also makes financial sense for PHS, explains **Lisa Farrell,** CPA, chief financial officer of Presbyterian Health Plan. "If our return rate continues to be that low, then we expect to realize a cost reduction in the next three to six months," she says.

Get physicians on board

While health system administrators saw the ED as offering the greatest opportunity for improvement in re-directing patients to more appropriate settings of care, the task of implementing the ED navigator program was by no means simple, stresses Farrell. "We went to the media, we went to advocacy groups, and we went to regulators," she says. "We really wanted to get out very broadly what we were doing." ***(For more on this aspect, see ED navigator programs require partnerships, communications, p. 55.)***

However, the most critical piece involved explaining the program to ED physicians and getting them on board. "Where I started from is trying to shift the paradigm of the ED being the safety net for all patients in the community," says Stern. "What we wanted to do was leverage the integrated system by spreading out the safety net to all parts of our system, so ED physicians had to kind of change their mindset."

Stern says he had to get the physicians to trust that there is a better place for the non-emergency patients to go, and try to hook up with a primary care physician (PCP) with whom they can develop an ongoing relationship. Still, the physicians had a number of concerns, including how long it would take for the navigated patients to be seen and treated.

"That was a deal-breaker for this program. If we couldn't get the patients to another venue of care within 12 to 24 hours, then we [agreed] we would stop the program that day," says Stern, noting that this also helped to ease concerns some of the physicians had regarding liability. "Most of the physicians agreed that these [navigated] patients would, in fact, be safer than the patients who are seen in fast track and then sent home, because the navigated patients would be guaranteed of being seen by a second provider within 12 to 24 hours."

Another big issue for the physicians was cost. They were concerned about patients having to pay for a second visit if they were navigated to another provider, so Stern offered a guarantee that the patients would at least be seen once at another venue of care at no cost to them. "If the patient had insurance, the insurance would pick up the cost of care, and if they had no insurance, then PHS would deal with the charity piece," says Stern.

Track and report benchmarking data

When the program first launched, the physicians were only comfortable with navigating patients with just a handful of minor diagnoses, such as sore throat, ear infection, urinary tract infections, and minor abrasions, notes Farrell. In addition, they stipulated that any patient under the age of 5 or over the age of 65 would not be navigated. However, the physicians' comfort level with the approach grew rapidly.

"Within about a week of launching the program, they said they were comfortable with the over-age-65 population. Within a couple of weeks, they were comfortable with the under-age-five population, and now any child over the age of three months can be navigated," explains Farrell, noting that the physicians themselves notified administrators when they were ready to expand the program.

The program has also been tweaked in other ways upon the suggestions of physicians, says Stern. "Someone came in with a minor sprained ankle, and the physicians didn't want to send the patient out limping, so they were allowed to give crutches to that patient," he says. "Similarly, if a patient needs one dose of pain medication, we will do that so the patient can get to a more appropriate venue of care."

While physicians have clearly warmed to the program, there are, nonetheless, varying degrees of acceptance. "There are some physicians who really embraced this early and are navigating upwards of 25% of the patients they see on a daily basis, but there are also some physicians who are still at zero or very low levels," explains Farrell.

Stern emphasizes that physicians are not under pressure to navigate patients, but he provides constant feedback on their use of the navigator program. "On a weekly basis, they get to see how they personally compare to their peers in navigating patients, so they know if they are in the 20th percentile, zero percentile, or 28th percentile," he says.

Stern will meet physicians who are low users of the program to hear their concerns and reinforce the

reasons behind the approach. "I don't force anybody to do anything, but I try to understand what their thoughts are and why they have been unwilling to navigate more patients," he says. "I have met with three physicians so far, and all of them were surprised that their numbers were so low," he says. "My guess is the next time we have this discussion, their numbers will be up."

Long-term goal: Change patient behavior

Also critical to the program are the ED navigators themselves, says Farrell. "They came out of our enterprise-wide contact center, so these are individuals who have a customer-service background, and they also have the ability to assign PCPs for our health plan members and to schedule appointments with providers in our primary care group," she says. "They have very broad access to the tools needed to get people into the right place, and they have the ability to talk to patients about the options that are available."

The way patients are navigated is crucial, because when you are sending patients elsewhere for care, there is certainly the potential for declines in customer satisfaction, but that hasn't been an issue for PHS thus far, stresses Farrell. "There are some hospitals that do navigation, but they just hand patients a list of 20 urgent-care centers and tell them that they can go to one of those. We don't do that," she says. "We actually take the time to sit down with the patients, talk to them about what we are doing, and get an appointment scheduled. We think that is one of the key reasons why we are not getting complaints."

In fact, the navigation process is an easy sell to patients who must pay for their care out-of-pocket, notes Stern. "When you tell them that [the care setting you are sending them to] is one-quarter or one-third of the cost of an ED visit, and that it is a much better venue for them for future [non-emergency] care needs, there are many patients who are very thankful for that because they didn't understand that they had other options," he says. "When we asked the patients we have navigated why they came to the ED, 93% indicated that they always come to the ED for care; it is how they have always cared for their family, and it is how their parents cared for their family, so there is literally decades of a culture of getting care in the community this way."

Currently, PHS has eight navigators who are covering two facilities, one of them remotely, and Farrell notes that ED navigators will begin serving a third hospital later this year. Coverage is around the clock, she says. However, the long-term goal of the program is not to keep navigating patients, but rather to change the way patients access their care. "In the short term, there is a lot of navigation going on, but over the long term, we expect that those individuals won't continue to come to the ED for non-emergent conditions," she says. "That is really the intent of the program: To change the behavior of individuals." ■

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ED navigator programs require partnerships, communications

As an integrated system, Albuquerque, NM-based Presbyterian Healthcare Services (PHS), is perhaps better-positioned than many health-care organizations to control all the levers that need to be pushed to get patients to the right venue of care, but **Lisa Farrell,** CPA, chief financial officer of Presbyterian Health Plan, emphasizes that the ED navigator model can work in other settings.

"There has to be a partnership with a payer that is willing to pay for the medical screening exam over the short term, and allow your cost structure to come down as people stop accessing the ED inappropriately," she says. "Right now, we have a lot of uninsured patients in New Mexico, and a very large percentage of the population is served by Medicaid, so 60% of the patients we are navigating are either uninsured or on Medicaid, where the reimbursement is very low, so for us the program makes a lot of sense."

In addition, Farrell points out that two Medicaid payers in New Mexico have begun to decline reimbursement for non-emergent care that is delivered in the ED, and health-care analysts expect that commercial payers will eventually follow suit.

For ease of scheduling, it is very helpful if the ED navigators have access to the schedules of community

physicians, says Farrell. But it is also important to reach out to community physicians, let them know what you are doing, and establish a communications mechanism so that any issues or problems that crop up can be resolved.

"If someone is inappropriately directed in either direction, we will jump on that very quickly and try to address where the problem was," explains **Mark Stern**, MD, medical director, medical management, and endcare coordination at PHS, and an emergency medicine physician. "We will investigate, review the chart, and get feedback to whoever the physician is on either side. That has been very effective to getting the physicians' trust."

To implement an ED navigator program, some hospitals might need to take on additional staff, but Farrell suggests that another option that may be particularly attractive to smaller EDs is to have registration personnel play a greater role in the navigation process. "We think there is a variety of ways to do it," she says. ■

Boost outcomes, shave LOS with ED-based intervention

Focus on geriatric fracture care patients

Hip fractures are among the most debilitating and expensive diagnoses to treat, but you can significantly improve outcomes and lower costs if you get hip-fracture patients into surgery quickly, explains **Anthony Balsamo**, MD, an orthopedic surgeon and head of the Geriatric Fracture Care Program (GFCP) at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA.

This is where ED personnel can play a crucial role in identifying fragility fractures, and linking these patients with appropriate care and education as swiftly as possible, adds Balsamo. "Statistics show that if you operate on someone right away, the results, in terms of morbidity and mortality, are significantly improved when the patient is over the age of 65," he says. "If you can get that hip stabilized, and you get the patient ambulating, there are fewer complications."

Balsamo established the GFCP in August of 2010, because he recognized the opportunities to improve care while also reducing length-of-stay and other costs associated with treating fragility fractures, which are common in older patients. With the baby-boom generation reaching retirement age, Balsamo notes that fragility fractures are expected to be a huge drain on health-care budgets going forward, particularly in regions like northeastern Pennsylvania, where baby boomers comprise more than 19% of the population.

However, optimal care involves more than just getting patients to surgery quickly. It also requires patient and family education and appropriate follow-up interventions to lessen the chances of a repeat fracture — all components of the GFCP, but Balsamo points out that much of this process begins in the ED.

Get family involved

Central to the GFCP is a geriatric nurse coordinator who works within the orthopedic department but is alerted to the ED via pager whenever an older patient presents with a fragility fracture — a fracture that is primarily the result of low bone density as opposed to trauma.

"We focus mainly on hip fractures, but I will see any geriatric fracture patient who comes into the ED," explains **Michele Gingo**, RN, the nurse coordinator of the GFCP. "I explain to them what their surgery is going to entail, what their recovery is going to entail, and I evaluate their home situation."

The main purpose of the interaction is to ensure that the patient and family understand what will be required for optimal recovery, and that they identify and remove any safety hazards that could complicate recovery and potentially lead to repeat fractures. "I educate the family that they are to go home and remove any throw rugs and make sure there are no

EXECUTIVE SUMMARY

Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA, has established a Geriatric Fracture Care Program (GFCP) to boost care of geriatric patients who present to the ED with fragility fractures. A primary goal of the program is to get the patients into surgery as quickly as possible because this can significantly improve outcomes and reduce length-of-stay.

- Key to the GFCP is a geriatric nurse coordinator who works within orthopaedics, but is paged to the ED whenever a geriatric fracture patient comes in for care.
- The nurse coordinator educates patients and families about what to expect from surgery and what will be required for optimal recovery.
- Outreach to ED providers is required to let them know about the program, but most providers are pleased to have added resources for their geriatric fracture patients.

extension cords in the way because when the patient comes home, he or she will most likely have an assistive device, and a throw rug or a cord could facilitate a fall," says Gingo.

In addition, Gingo explains that while pain medication will be available, patients should not expect to be pain-free right away. "We need them to be able to participate in therapy," she says. "We don't want them to be sleepy and unable to get out of bed the next day, so I explain that bed rest has many complications including, but not limited to, blood clots in their legs or lungs and pneumonia."

Gingo provides the family with a packet of information they can use as a resource for such questions as how to get in and out of a car after surgery or how to get dressed, she says. It also includes information about osteoporosis, since most of these patients will require follow-up treatment to strengthen their bones and prevent future fractures. "While patients are in the hospital, a rheumatologist will see them for our high-risk osteoporosis clinic, and there will be a follow-up office visit with the rheumatologist in a few weeks," says Gingo. "I explain to them what is going to happen. They will see physical therapy, they will see occupational therapy, and they will see a clinical nutritionist."

While hip fractures are a priority, Gingo sees other geriatric fracture patients as well. In those cases, she may help with splinting or casting, and she will discuss with the ED provider whether the patient should be referred on to the high-risk osteoporosis clinic. In the case of an ankle fracture where there is too much swelling for surgery, for example, the injury may be splinted and the patient sent home until the swelling goes down, explains Gingo.

Communicate with providers

It took some time to get the ED physicians accustomed to the new program, acknowledges Gingo. In the early stages of the program, she would reach out to the ED physicians when they had geriatric fracture patients and explain her role. "It is key to talk to the providers and let them know that you are eager to be [called in on a case]," she says. "I take the beeper home with me, and while I won't return a call in the middle of the night, they know I will be there first thing in the morning."

Now ED providers are part of the GFCP approach, and they appreciate having a nurse who can come down to the ED and spend more time with their patients than they are able to do. "ED doctors buy into the program because there is all this information for them, someone is organizing it, and care is not delayed," says Balsamo. "Nothing is keeping that patient from surgical intervention." ■

SOURCES

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Survey: On-call surgical specialists hard to find; lack of incentives may be a root case

EDs wrestle with shortages; make greater use of mid-levels

With all the talk about the shortage of primary care physicians, one would think there is an abundance of surgical specialty care providers ready and willing to answer the call. However, while there may be an ample supply of providers in many specialty areas, that doesn't necessarily mean they are readily available to emergency departments (EDs). To the contrary, a new survey of a national sample of ED directors suggests that problems with on-call coverage are widespread.[1]

In fact, the authors report that inadequate on-call coverage of specialty surgical providers is linked with 21% of the deaths and permanent injuries that occur in the ED. They're stressing that the issue needs to be dealt with as policy makers wrestle with issues of quality and the implications of health care reform.

Dearth of specialty providers a widespread concern

Mitesh Rao, MD, MHS, a physician in the department of emergency medicine at Yale University in New Haven, CT, and the lead author of the study, explains

that while he is fortunate to work in a Level 1 trauma center where there is access to just about every type of specialist, his colleagues who work at community hospitals frequently comment on the enormous amounts of time and effort required to get appropriate care for their patients.

"Almost everybody has an interesting story about a patient who they would try to get care provided for at another hospital, but that patient would usually have to travel long distances and wait a long time in order to get approval from that other hospital for the transport," says Rao. However, Rao observed that aside from a handful of state-level studies and a few commentaries, there wasn't anything in the literature that captured the scope of this problem on a national level. "I thought that at this stage, we didn't have the most up-to-date data on what is going on [with on-call coverage], so I decided to see if I could collect it."

Using a survey that was reviewed by emergency medicine experts and pilot tested for content and readability, Rao and his coauthors surveyed a national sample of ED directors at 715 hospitals that offer a full range of emergency care services; specialty providers such as women's or children's EDs were excluded. More than half of those surveyed responded, for a response rate of 62%, and the results were sobering.

Nearly three-quarters (74%) of the respondents reported problems with on-call coverage of specialty physicians, and 60% said they had lost 24/7 coverage of at least one specialty in the last four years. Further, 26% reported some unreliability in their on-call coverage, and 23% noted that their trauma center designation had been impacted by their on-call coverage difficulties. A number of survey respondents (22%) also reported that problems with on-call coverage had caused an increase in their leave-without-being-seen (LWBS) rates.

Broken down by specific specialty, the most widespread problems with on-call coverage pertained to plastic surgery coverage (81%), hand surgery coverage (80%) and neurosurgery coverage (75%). However, 35% of respondents reported they had difficulty maintaining adequate coverage for general surgery, and 6.5% reported having no on-call coverage for general surgery.

Teaching hospitals appeared to be somewhat better off than non-teaching facilities with respect to on-call coverage in their EDs; 68% of respondents from teaching hospitals reported problems, as opposed to 78% of respondents from non-teaching hospitals. And problems appeared to be more widespread in the South than other areas: 81% of respondents from Southern hospitals reported problems with on-call coverage, as compared to 62% reporting problems from hospitals in the Midwest.

Consider incentives

While the numbers suggest there is a shortage of specialty providers in some areas, such as neurosurgery, for example, Rao emphasizes the root cause of on-call coverage problems may have more to do with a lack of incentives for specialty providers to accept on-call coverage responsibilities.

"Once upon a time it was the norm that specialty physicians would come out of their training and take call in the hospital. That would be how they would develop their practices," explains Rao. "But now these physicians graduate with specialty surgery fellowships, and they join group practices, so there is no practice development [needed]."

Further, Rao points out that there are actually disincentives to coming into the hospital in the middle of the night to provide care. Not only does it take physicians away from their families and make it difficult to resume their normal schedule the following morning, there is also a higher risk of liability. "Treating patients who you don't have an established relationship with can translate into increased malpractice costs," says Rao. "And there is also always the risk that you come in the middle of the night [to treat a patient] and there is no reimbursement. For physicians in private practice, that is not a plus."

While there are no easy answers to the on-call coverage dilemma, Rao explains that some hospi-

EXECUTIVE SUMMARY

A new study suggests that EDs across the country are experiencing difficulties because they don't have adequate on-call coverage by surgical specialty providers. The lead author indicates the root cause of this problem may have more to do with a lack of incentives for providers to accept on-call coverage responsibilities than an actual shortage of surgical specialists. Solutions to the problem may include a greater use of mid-level specialty providers, and more regionalization of care so that resources are managed more effectively.

- According to a survey of ED directors, three-quarters of respondents report having difficulties with inadequate on-call coverage.
- Respondents from the South reported the most difficulty, with 81% indicating they have problems with on-call coverage.
- The most serious problems reported with on-call coverage pertain to plastic surgery (81%), hand surgery (80%), and neurosurgery (75%).

tals are having some success with the use of specialty mid-level providers. "Having an orthopedic physician's assistant in-house who can come in and see patients alleviates a lot of the issues with on-call coverage," he explains.

Other solutions include better management of resources so that patients with specific needs are immediately routed not to the nearest hospital necessarily, but to the hospital that has the specialty care that will be needed for that patient's care, adds Rao.

"That has to do with the regionalization of care so that we organize our resources so that we know where specialty physicians are available, and we can get patients to the right place as opposed to getting them to the first place and then having delays in care that can lead to morbidity and mortality." ■

REFERENCE

1. Rao M, Lerro C, Gross C. The shortage of on-call surgical specialist coverage: A national survey of emergency department directors. *Acad Emerg Med* 2010;17:1-9.

SOURCES

For more information on incentives, contact:
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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. ■

COMING IN FUTURE MONTHS

■ Human trafficking and the ED

■ Care transitions: Get around the hand-off problem

■ How will the ACO model impact EDs?

■ Accreditation: Are you ready for new communications standards?

CNE/CME INSTRUCTIONS

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME QUESTIONS

1. The primary motivation behind QTrack, a new ED protocol developed at Ochsner Medical Center in New Orleans, LA, was:
A. to find a way to move ED patients through the system more efficiently without utilizing more resources.
B. to get providers to work in teams.
C. to get patients with non-acute issues to seek care elsewhere.
D. to reduce the cost of providing emergency care.

2. In the QTrack process developed at Ochsner Medical Center in New Orleans, LA, the "rule of two" refers to:
A. a requirement that all ED patients are evaluated two times before being discharged.
B. a requirement that you can put not more than two patients in a treatment room at the same time.
C. a requirement that patients can receive no more than two bags of fluid or two doses of medicine while remaining in a recliner.
D. All of the above

3. The most critical piece in implementing an effective ED navigator program is:
A. getting patients to agree to travel to another location for their care.
B. getting emergency physicians to buy into the program.
C. finding personnel with the proper training to provide navigation services.
D. getting payers on board with the approach.

4. The ultimate goal of the ED navigator program at Presbyterian Healthcare Services in Albuquerque, NM is to:

A. improve patient flow through the ED.
B. ease overcrowding.
C. boost patient satisfaction.
D. change the way patients access their care.

5. One of the primary goals of the Geriatric Fracture Care Program at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA, is to get patients who present to the ED with hip fractures into surgery as quickly as possible. Why is this important?
A. Because hip-fracture patients are a common source of backlogs in the ED
B. Because statistics show that if you operate on a hip-fracture patient right away, the results in terms of morbidity and mortality are significantly improved when the patient is over the age of 65
C. Because older patients have less tolerance for pain
D. Because ED physicians often don't have the time to treat hip-fracture patients

6. A new study shows that EDs across the country are struggling with inadequate coverage by surgical specialty providers. However, the lead author of the study, **Mitesh Rao**, MD, MHS, a physician in the department of emergency medicine at Yale University in New Haven, CT, suggests the root cause of this problem is not necessarily a shortage of such providers. What is the primary source of this problem, according to Rao?
A. A lack of incentives to provide on-call coverage
B. A fragmented health-care system
C. Inadequate communications
D. Lack of funds