PREPARING FOR PATIENT DEMAND UNDER REFORM: DOES YOUR ED NEED AN OVERHAUL?

The Patient Protection and Affordable Care Act is bringing significant change to the healthcare industry, and with that change come increased stresses. Perhaps the law’s earliest impact will be felt in the emergency department, as thousands of people who were formerly uninsured seek care there due to a general shortage of primary care physicians. With many EDs already running at capacity, how does a hospital leader create new systems and expand capacity to meet increasing patient demand, as well as the increasing demands of care coordination? Learn from some of the industry’s leaders in this condensed version of a recent conversation moderated by HealthLeaders Media.

Panelist Profiles

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Roundtable Highlights

HEALTHLEADERS: Many of you have done some reengineering work in your EDs. How do you begin to create new systems and new capacity to meet increasing patient demand?

JONATHAN DAVIS: You can never fail by being efficient. What are all the touch points and how do we pull the team together both on the inpatient side and the emergency room side to make sure it’s streamlined? I certainly don’t have a crystal ball to forecast what the future looks like, but we are working diligently to provide the best-quality care, efficiently.

JASON HUNT: We recently consolidated our two emergency departments—making a 65,000-volume ED into a 100,000-volume ED overnight without adding bed capacity. So our focus was on improving efficiency as well. It was all about leaning up our processes as much as possible and looking at more creative ways of using available bed space. This primarily boils down to utilizing waiting room spaces for patients who have already been seen.

LYNN MASSINGALE: Our partner hospitals that are making the most progress seem to have certain things in common—most notably, that everyone shares in the responsibility of the final product. The ED team and hospital administration collectively admit there is a problem, and everyone takes responsibility for the problem while they work together on a solution. The hospital CEO really needs to focus on this, hold us all accountable and recognize progress, even if it’s small progress.

ROBB WHITE: For us, the largest piece was putting together a team that works on the emergency department’s operations and processes and getting those turnaround times really leaned out. When we got those down, we were able to see more patients more efficiently. We take ownership of the department and see a patient who has left without being seen as a missed opportunity, a failure of the emergency department and the hospital as a whole to meet that person’s need.

HEALTHLEADERS: We’ve seen capacity concerns in Massachusetts, which has been covering its uninsured since 2008. Previously uninsured patients had been using the ED for their care and continue to do so, in greater numbers now. Will this be a problem at your facilities?

DAVIS: If more people have insurance and go to the ER, but we don’t do anything to create family health centers and put more primary care into the community, absolutely. My goal is to have enough redundancy in the system that regardless of the circumstances, it will never fail. For example, we’ve implemented a QuickCare clinic on-site. It is staffed by physicians and mid-levels. Since 30% of our 70,000 visits are nonemergency, that’s a great way to increase access to care. It’s affordable, and you’re not going through all the elaborate ER processes, saving those for true emergencies.

HUNT: On-site quick care is a great idea; however, it’s important to make sure the public is educated that this is available for nonurgent problems to get them to self-triage, eliminating the need to shuffle people back and forth between quick care and the ER. We have a fast track as part of our ED that we run using a mid-level provider. It’s seeing about 50 patients a day utilizing only two beds and its own small waiting area. We are looking to expand that in the near future. Doing so will help significantly improve some of our capacity issues.

MASSINGALE: Our hospitals also use fast tracks in the ER so we can treat lower-acuity patients using nurse practitioners or physician assistants at a lower expense, and we have some hospital-affiliated urgent care clinics. In addition, from an industry perspective, there is a great need for primary care and chronic care, and yet fewer and fewer physicians want to be primary care physicians. So something has to happen to primary care physician compensation to attract more people to primary care. I don’t think hospitals can shoulder this burden indefinitely.

HUNT: Everyone who is discharged through our system goes through a single point. This area has dedicated nurses who are familiar with the community’s resources, whether it’s free clinics or dental clinics. They can also get patients financial counseling to get
them signed up for Medicaid or other assistance. That way the next time we see them, hopefully they will have some form of medical coverage. It also helps the nurses in the treatment areas by taking this burden off them and helping to improve the turnover of vital bed space. They are able to do a lot of service recovery as well. This area has been a big success for us.

HEALTHLEADERS: Let’s talk about process reengineering that you all have done to enable better throughput.

DAVIS: When I came into the organization, I heard that we had a 13-year-old problem. A lot of patients would leave when they stepped into the crowded waiting room. Our strategy was to capture the business that was leaving, so I pulled a patient access team together. I led that committee because of its organizational priority. We’re approximately 225 staffed beds and we see 70,000 annual visits to our ER. If you look at other places that see that volume, they’ve got 700 beds. This was a systemic issue, not just ER. So in solving the problem, we had to look at the entire continuum from when the patient walks in to when he or she is discharged. The biggest struggle for our organization was getting through years of commentary and anecdotal nonfacts.

HUNT: We had outside consultants come in and see how much savings there would be by combining the two emergency departments. The physicians had felt for a long time that it was very inefficient to try to man two ERs literally steps away from each other. The challenge was to figure out how to move all of that volume into one box. So we visited a lot of other hospitals that were doing different things like putting physicians in triage and coming up with ways to move patients out of beds and into waiting spaces. We broke down all of our processes piece by piece. When you look at each step, you realize how much of the patient’s time is wasted just waiting for the next step. The more things you can do in parallel, the better.

WHITE: We brought everybody together about three years ago and recognized that the processes that we had were noneffective at the time. As a community-based hospital, we still have some significant challenges with our community-based physicians and the limitations of that model. We’ve made significant process from evening rounds with evening discharges to actually making rounds at lunchtime and being in the hospital early in the morning and doing those discharges. The other side of healthcare reform is that, curiously, it has gotten community-based physicians to reengage and to recognize that it goes both ways. We had 20 or 30 cases in surgery on Saturday a couple of weeks ago, which is a pretty significant caseload for a Saturday for a community hospital this size. But that really helps with the ER, believe it or not, because those are surgery beds that are available during the week. It’s rethinking patterns of work.

MASSINGALE: I agree with Jonathan when he said something to the effect of, “We don’t have a bed problem; we have a doctors-getting-patients-discharged problem.” In many cases, there are a lot of patients who could leave the hospital if they could be discharged by somebody—the hospitalist or their primary attending physician. Where we have a hospitalist program, we’re calling the hospitalist in on essentially all the medical patients, with a few exceptions. In a few of our hospitals, our hospitalists admit everybody except the cases going straight to surgery for trauma. If you’re in a situation where you’ve concentrated all admissions into the hands of two hospitalists, for instance, that can be a bottleneck that needs correcting.

HEALTHLEADERS: Are the rest of you seeing the same sorts of problems with getting patients admitted even if you have space?

HUNT: We also face the challenge that essentially the entire volume of medical admissions has been concentrated on the backs of just the hospitalists. Some of the hospitalists are good about sorting through this load, but others struggle. I don’t think dealing with mass triage is part of the typical internist’s training. It is part of the ED physician training to deal with the truckload of patients just emptied into your waiting room at once. You can’t see one patient and follow it to the end before going on to the next one. I think there is a different mind-set between the two specialties, and sometimes that causes friction.

DAVIS: One of the reasons we opened an express admission unit was to assist community physicians with direct admits, bypassing the ER and reducing the number of patients holding in the ER. The job of our EAU staff is to go to the ER and “pull” patients out of the ER. There shouldn’t be a “push” effect because the ER physician and the
staff are dealing with multiple patients and the last thing they need is patients holding in the ER. Additionally, if the ER physician knows a patient needs to be admitted, the hospitalist takes the patient and gets him or her admitted. That’s teamwork, where everybody’s successful together, not one at the expense of the other.

MASSINGALE: In hospitals where we have both ER docs and hospitalists, we have implemented aligned incentives. The ultimate goal is to transition patients from the ER to the floor more quickly, and so both parties are incentivized to work together to make this happen. A few cross-incentives that we have not yet implemented, but I think would be instructive, would be to provide a financial incentive for the hospitalist if the ER docs hit their left-without-being-seen and door-to-doc metrics. Likewise, you could incentivize the ER docs if the hospitalists hit their metrics through core measures—things like hospital length of stay and reduced readmissions.

WHITE: When I first came here, the hospitalist program was in its infancy. What was happening was that the ER docs were writing very comprehensive admission orders and actually were doing some chart reviews. A few times, only two orders were written past the ER admission orders because the ER docs were writing such comprehensive orders. That’s great in a sense, but it’s also bad. We’ve modified that considerably.

HUNT: Even before we consolidated, part of our volume strategy was moving patients who were waiting to be seen by hospitalists out of the emergency department into an admission unit. We also use that unit to place patients who have been directly admitted from an office or regional transfer if no inpatient bed is available. One of the unforeseen consequences has been that while we may get the patients out of the emergency department into an admit unit, it has created a buffer for the admitting physicians, resulting in even longer delays getting the patients into an inpatient bed. The patients are still backing up in the ED because the admit units are now overflowing with patients. It may just be an expensive solution to what is really a physician manpower or workflow problem.

DAVIS: Part of our challenge was when we looked at the process, we had our admit nurses floating throughout the house. It was disorganized. To further exacerbate the issue, at discharge time a floor nurse would have five patients. Three of those were being discharged, the ER would be sending up three more, and now the floor nurse might have eight patients. And they’re doing paperwork on six of the eight. We took the admit nurses and moved them up to a designated admissions unit so they could own the entire admit process. We took much of the discharge process away from the floor nurses so they could provide care to patients.

MASSINGALE: There are very few cookie-cutter answers to this and people are out there selling some cookie-cutter solutions. It really takes hard work on an individual basis coupled with a lot of creativity and a lot of interim solutions. You have to live with some of that. There’s no substitute for leadership. It takes a lot of hard work and a lot of leadership.

DAVIS: I felt our patient access team was not an acute fix to the ER’s problems. It’s a permanent team championing organizational throughput. We initially met once a month, now quarterly.

HEALTHLEADERS: Let’s talk about the teamwork aspect of this work. All of these folks have to work together for the ultimate goal, which is to move that patient through in the most efficient manner possible. Are there ways to foster that kind of teamwork?

DAVIS: You can’t just write an algorithm to it. The way I started it was to say, “I trust you with the patients who come here. I trust you to take care for our community and I trust that you are excellent providers.” They need to hear that. Sometimes we as leaders get caught up in addressing the negative. That’s the easiest part. It’s important for us as leaders to pass along the compliments and celebrate the rewards, changes, outcomes, and all the wonderful patient experiences.

MASSINGALE: Good teamwork starts with selecting good people. There are some people who either aren’t trustworthy or aren’t going to engender trusting feelings, and it’s important to figure out in the interview and hiring process and take your time with your selection. People who are unable to engender trustworthiness or provide positive feedback are really hard to build a team around, especially if they’re in a leadership role. We’ve invested in a lot of medical director training at TeamHealth because the
medical directors are the linchpins. It’s critical that we provide them with total support in order to ensure a successful relationship with our hospital partners.

HEALTHLEADERS: Technology is often a huge part of reengineering and making emergency departments more efficient. Often the ER is the first place hospitals introduce new technology. Is technology helping or hurting ED efficiency?

HUNT: Technology integration has been a net positive, but there have been some negatives, too. We’ve been on patient tracking for several years, and that’s undoubtedly been a huge benefit, as is having immediate access to medical records. Our physicians have been using CPOE for more than three years, and that’s been more of a mix. Some things are excellent about it—for instance, the drug interaction and allergy checking is a big safety improvement. One downside has been that some of the physicians feel that in our system it’s potentially easier to enter orders on the wrong patient than it was when you had to physically pick the chart out of the rack. I think the real unforeseen consequence has been that it tends to pull attention away from the patient’s bedside and direct it toward the computer and nursing unit. This has been particularly noticeable as nurses moved to computerized documentation, despite having computers in every room. Good care is still being delivered, but the patients in particular miss the bedside interactions. If I were starting from scratch in the ED, I would look hard for a best-in-breed ED solution and then make it interface with the inpatient system.

WHITE: We had a different experience. In the ED, we were the first ones in the hospital to go completely to an electronic record. We were very careful about how we chose that vendor and really did a lot of analysis prior. That happened three years ago. For us it’s really been beneficial. It’s provided us with a lot of benefits in terms of turnaround time and patient experience. Our approach was to de-anchor nurses from going behind the nurses’ station. If you get the nurse away and they’re doing that clerical work, they’re not at the bedside. We have stand-up units, we have carts, we have tablets, and we’ve got wall-mounted units in the rooms.

DAVIS: We use a patient tracker board, but we’re just now putting in CPOE. All of us on the ED project are fairly nervous because of the volume of patients we see and we’re concerned about a slowdown. A normal anxiety is making sure we are productive and effective at meeting our patients’ needs in a timely manner.

MASSINGALE: For more than 10 years we’ve made big investments in IT because we believe in the necessity of having actionable data. We have 130 full-time IT employees just in our organization. So we’re all about IT. We have a full-time clinical informatics officer who serves as a wonderful interface between the IT people and the doctors. He helps us communicate with each other and he’s been a huge advantage. But it’s not easy to find that kind of support.

HEALTHLEADERS: Let’s talk about staffing outside of doctors and nurses. Do any of you have one person or one group of people who’s responsible for reaching your throughput goals?

HUNT: We have groups looking not only at improving throughput, but also at ways to better keep the people who are waiting informed how long it is going to be, where they are in line, and what they can expect next. Everybody needs to share that task, but it would also be nice to have somebody whose job it is to make sure patients get a warm blanket, food or water, or keep them informed when the physicians and nurses are busy with others.

DAVIS: Our goal is to decrease the wait time, and we decided to focus our resources on that, knowing it is a team effort. We made it all of our jobs to provide timely care for patients coming to us. We do have a hospitalwide patient liaison who assists our leaders in service recovery.

MASSINGALE: We have worked in places off and on through the years that have a patient care coordinator or somebody who does some of those things. One of our regions has used scribes. They actually call the scribes CIMS or clinical information managers, and in addition, they created the medical record. They’re the ones who keep the family informed and they bird-dog the lab results.

WHITE: At Tomball, the responsibilities of that job are shared between the house supervisor, who’s motivating folks to pull from the emergency department, and the ED charge nurse. I really push my clinical manager and my ED charge nurses to be rounding on the patients and their families and to always be moving and looking for the roadblocks. We use specific tools to identify where those roadblocks are.

HUNT: We have new leadership at Mission who see the importance in efficiency. We are in the process right now of creating a systemwide patient throughput team with some smaller working groups that will be doing cycles of 90-day process improvement projects. They’ll be starting at both the admission and discharge ends, working their way to the middle. So I’m quite hopeful that we’re going to see a lot of throughput improvements systemwide. It is important to realize that throughput can’t be focused only on the ED and it must originate from the top levels of administration. Someone has to take ownership of it from the leadership’s perspective. It can’t be left for the ED to fix from the bottom up. It just won’t happen that way.
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