Simple Changes for ED Results

Improving patient flow through a busy emergency department does not have to be as expensive or as complicated as the cases that come through the door.

BY JACQUELINE FELLOWS

The effective and efficient triage of patients is key to the flow of an emergency department. Not only for practical reasons but also because a new survey measuring patient satisfaction in the ED is on the horizon. ED-CAHPS—similar to HCAHPS, the survey that allows patients postdischarge to rate hospitals on communication, noise level, and other factors—is in development now.

Providers originally expected the Centers for Medicare & Medicaid Services to begin using ED-CAHPS this year, but delays have pushed it back to 2016. Still, hospitals and health systems that have made patient experience a priority are not holding back on preparing for ED-CAHPS.

But surveys are not the only driver, nor even the main driver, of organizations’ repeated attempts to reorganize processes for better throughput. When EDs are crowded with patients who can be treated elsewhere, it prevents patients with acute needs from being seen quickly, which can impact cost and quality.

While frequent fliers to the ED have been a focal point of throughput improvement, some hospitals have complemented those efforts with new strategies. For example, some organizations are designing elder-friendly EDs because such patients represent a significant percentage of ED visits. Hospitals that are building new EDs are using the construction as an opportunity to re-create the space for improved function.

Organizations using these approaches are finding that the changes they have to make are relatively simple, inexpensive, and effective. The changes also could have a positive impact on patient satisfaction and experience benchmarks.

Success key No. 1: Change the flow of patients

Grady Health System in Atlanta has one of the busiest EDs in the city, seeing more than 125,000 patients annually. Construction has started for a 15,000-square-foot addition to the ED. That’s scheduled to be complete in late 2016, but some bottlenecks need
“We’re pretty tight on space, given our volume. We’ve started focusing on which patients can be treated vertically so they don’t need to lie down on a stretcher.”

determination in early 2014, it had developed other approaches to improve its ED metrics. Atallah says ED staff frequently would provide updates to patients in the waiting room on how much longer it would be until they could be seen.

“Two big things that really impact patient experience in the ED are door-to-provider times and keeping the patient informed,” he says. “We would say [to the patients waiting], ‘We are working as fast as we can, and we are currently seeing people who have arrived at—’ and we would give a specific time.”

The hourly communication and addition of dry-erase boards helped some, but Atallah says patient experience in the ED improved more when advanced practice providers were added to the ED staff.

“We went from 13 advanced practice providers to 21,” he says. “More patients can be treated vertically, so we need to have enough people to treat them. Faculty, residents, and leadership made sure they were integrated into the practice of care. They help move people along and catch people who can slip through the cracks.”

A frequent complaint from ED staff is about the patients who come in for minor illnesses that can be treated at a doctor’s office. The walk-in clinics and urgent care centers that increasingly are popping up do absorb some of that traffic. Grady Health System built a walk-in clinic in 2011 that is on the same campus as its main hospital.

“They’re peeling off about 80 visits a day for low-acuity patients,” Atallah says. “We also have a process where we medically screen every patient by an attending doctor who can explain that a patient will get faster care at our walk-in clinic.”

Grady Health System’s walk-in clinic, which is open Monday through Friday from 8 a.m. to 8 p.m., has helped to ease the low-acuity ED traffic, but its effectiveness has plateaued because the hours of operation do not coincide with busy overnight and weekend traffic in the ED; plus, overall ED volume at Grady Health System has increased.

Atallah attributes some of the ED volume growth to the economy and the performance of the organization’s stroke center.

“We have 24/7 cardiac catheterization capability, and we’ve seen a huge growth in treating stroke patients,” he says. “We’ve also seen the volume of mental health patients go from 200 per month in 2010 to 800 a month today.”

Despite the challenges that Grady Health System’s ED is facing, Atallah says there are positive signs that simple changes can work. A patient’s door-to-provider time has improved. In 2013, before the changes to patient flow, patients were waiting an average of 133 minutes to see a provider. Atallah says the ED finished 2014 at 105 minutes, and in January of this year, it was down to 98 minutes.

As for patient experience, that is a tough nut to crack for an organization, especially in the ED, where it is noisy, busy, and many patients may see themselves as a top priority. Even in Grady Health System’s ED, Atallah says there is a long way to go, but is encourage by a positive trend.

“We started 2014 in the 1st percentile,” says Atallah. “But we finished in the 28th percentile, and our goal is to get to the 55th this year. The key thing we’ve learned is you have to keep making patient experience a priority.”

**SERVICE LINE INVESTMENT**

Percent of organizations that expect to begin or increase investment in service line redesign or realignment over the next three years.

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<th>All Hospitals</th>
<th>Health systems</th>
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<td>41%</td>
<td>44%</td>
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Multi-response

NOTE: This chart includes data segmentation from the Premium edition of the report.

SOURCE: HealthLeaders Media Industry Survey 2015: Succeeding in the Risk Era: How to Accelerate Progress Toward a Value-Based Future, January 2015; hlm.tc/1DZUrEu
Success key No. 2: Stratify for senior care
One of the newest trends in ED throughput is giving special attention to seniors who present.

ECRI Institute, the nonprofit health research organization based in the Philadelphia suburb of Plymouth Meeting, Pennsylvania, listed geriatric ED units in its 2014 Top Ten Hospital C-Suite Watch List because of the aging baby boomer population.

Grady Health System does not currently have a specialized geriatric ED unit, but Atallah says the idea has caught the emergency department’s attention. “We’re going to try to implement specialized geriatric treatment rooms in our new ED,” says Atallah.

One of the first EDs built specifically for seniors is in Silver Spring, Maryland, at Holy Cross Hospital, a 437-bed nonprofit teaching hospital that is part of Holy Cross Health, which is part of Livonia, Michigan–based Trinity Health.

The senior emergency room opened in November 2008 after Holy Cross Hospital CEO Kevin Sexton noted that the care his mother had received could have addressed her needs differently. “She was in her late 80s, and the experiences she had and he had when he visited her were of a big, busy, loud emergency room, like all emergency rooms tend to be,” says Blair Eig, MD, chief medical officer for Holy Cross Hospital.

Eig says that at the time, the hospital had a big enough footprint to make space for a seven-bed senior emergency room. He says they moved what was a fast-track urgent care section of the ED up one floor, then reconfigured the space to cater to seniors and their families.

“The changes aren’t necessarily complicated, but you’ve got to think about it in terms of what the seniors need,” says Eig. “It’s changing the lighting, the paint on the walls, the floor color so it is easier for seniors to navigate.”

Eig also says walls were put up between the seven bays to reduce noise. Mattresses are much thicker, and telephones and remote controls have larger numbers so they’re easier for senior patients to see. Blanket warmers and space for families were added to the rooms, too.

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“Some of it might look like window dressing, but it just was directed at the senior’s needs,” says Eig.

And the cost to make those changes? Low—only $150,000.

“It was simple things that didn’t cost a lot of money,” says Eig. “We, in hospitals, had tended to do things that are good for the hospitals. To provide the best care, we started thinking what is best for our patients who use the hospital.”

The volume of seniors treated at the Holy Cross Senior Emergency Center has grown steadily to an average of 3,358 patients, a 5% increase over its first-year numbers. About 24% of the seniors who come through the Holy Cross Hospital ED end up using the hospital’s SEC.

The criteria for being seen in the SEC are that patients must be over 65 years old and stable. Acute senior patients still have to be seen in the regular ED, but Eig says that all of the staff at Holy Cross has received specialized senior-care training through workshops that aim to help providers understand seniors’ needs.

“As our patient population becomes older, those patients become more and more complex,” says Sue Penoza, BSN, MA, RN-BC, director of growth and strategic leadership at Trinity Health. “That doesn’t necessarily fit with EDs that were developed in the 1950s, 60s, and 70s, when the population was younger. For example, we want rapid diagnosis, treatment, and disposition in EDs, but that doesn’t necessarily fit with our older population’s greater needs, which may have multiple medications, changes in their mental status, and multiple chronic diseases.”

Penoza also says that Trinity Health recognized the need for more senior
emergency rooms and recommended in 2010 that all Trinity Health hospital partners implement an SEC like the one at Holy Cross. According to Trinity Health’s data, its seniors comprise a larger percentage than is present in the general population.

“According to the U.S. Census Bureau, 13% of the population is age 65 or older,” says Penoza. “In Trinity Health legacy hospitals, 19% of ER visits are 65 and older ... 50% of patients admitted to the hospital through the ER are age 65 or older.”

The idea of having senior emergency rooms at every Trinity Health hospital was short-lived. Penoza says it became clear quickly that other ED initiatives needed to move forward first. So instead of a directive to hospitals, it became a suggestion, one that 13 hospitals, to date, took to heart, including Saint Alphonsus Health System, a four-hospital system with facilities in Idaho and Oregon.

It’s one of the newest hospital systems to answer Trinity Health’s call for setting up a senior emergency room.

“We saw this as a way to provide better service at the local level for seniors but also to show a regional Trinity Health approach and customize at each of the communities,” says Ray Gibbons, FACHE, CEO of Saint Alphonsus Medical Center-Baker City, a 25-bed critical access hospital in Oregon. It’s part of the St. Alphonsus Health System, which is setting up four additional senior emergency rooms at its facilities.

Gibbons says his hospital is building on concepts tested by Holy Cross and implementing them locally, such as quieter areas, better lighting, and softer colors on the wall. The patient population specific to the Baker City facility is a natural fit for senior emergency rooms, says Gibbons.

“In our communities, the seniors’ families—adult children—they’re not in the community anymore; they’re far away,” he says. “So we have trained the emergency room staff to use words that are comforting to the patient, to frame a question better, establish compassion, and know when to take a pause and listen.”

Since opening its first SEC at Holy Cross Hospital, Trinity Health has gleaned what Penoza says is valuable information about the senior population. For example, Holy Cross uses a risk-assessment tool in its SEC to get information about medication, recent falls, mental status, and daily living activities.

“We found 17.4%–20% of patients age 65 and older admitted to the ER are from a senior facility,” Penoza says. “Why is this important? Clinicians need to understand what types of services are available in the senior facility to generate referrals appropriately.”

That risk assessment also is used by a social worker to follow up with patients when they are discharged from the SEC. Eig credits the social worker follow-up for a large part of the SEC’s success at Holy Cross.

“The service being provided by the social work has, besides leading to greater satisfaction for our patients, also ensured better follow-up for patients, whether it is in a physician’s office, with medication, etc. That has lowered readmissions for that patient population.”

As far as the effect on the overall ED throughput at Holy Cross Hospital, Eig says it increased ED volume because the word was out in the community that the resource existed, but the segmentation allowed for better throughput overall in the ED.

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“By taking the seniors to an area off the main ER, it freed up space in the main ER for managing more acute cases and younger patients,” says Eig. “It also allowed more time for seniors. It often takes more time to evaluate, treat, and either admit or release seniors.”

EDs set up specifically for seniors are not widespread, but they may be more common as the population ages and hospitals look for population health strategies.