Introduction | Accepting ED Excellence

This is the INTRODUCTION from HealthLeaders Media Breakthroughs: The Coordinated ED
The emergency department has long been thought of as the front door to the hospital or health system. That’s partly by design for organizations that market their EDs as a place to get prompt quality care—from posting wait times on billboards and online to employing patient navigators to making sure signs directing visitors to the ED are clear and that parking is plentiful. The ED has also been the front door by default, the catch-all healthcare center open 24/7 with doctors to cover whatever ails their patients.
In fact, because the ED has become such a main and often single point of contact for patients—and volume for hospitals—that it’s raised policy questions about whether EDs should continue their role as the front door or if patients should be encouraged to seek alternative (and less expensive) treatment options.

In a reimbursement environment increasingly focused on value and coordination, ED care has been depicted as either overused or overbuilt. ED leaders point out that emergency care can be cost-effective for the patient and profitable for the hospital. And the American College of Emergency Physicians says emergency medical care accounts for only 3% of all U.S. healthcare spending, treating 120 million patients each year.

Perhaps the debate over whether the ED is the appropriate venue of care misses a larger question about how ED excellence fits into your health system, says Leon L. Haley Jr., MD, deputy senior vice president of medical affairs, chief of emergency medicine for Grady Health System in Atlanta.

The question of whether the ED is the front door, side door, or back door depends on who’s asking the question, Haley says. “From a patient’s perspective it is often seen as the front door. You can decide what you want. But what your ED has to be is one of your centers of excellence. No matter what your health system’s focus is, whether you are a cardiac-focused hospital or a geriatric-focused hospital, your ED has to be one of your centers of excellence. It can’t be an afterthought. It has to be included in how you are thinking about your marketing plan, how you are thinking about your finances and billing, and what your contribution margins are. Your ED care has to be top-notch. The doctors have to be some of the best you have at your institution. It has to be one of your centers of excellence whether you call it the front door or back door.”

As an entity that must be adaptive enough to treat anything that walks through the door, the ED can be a complex unit to run efficiently. Half of national hospital inpatient admissions still come through the ED—and if throughput is clogged, the downstream complications for outcomes and satisfaction plummet. The ED is also the locus for many of the issues putting stress on hospital-physician alignment, with increasing numbers of specialists flexing their way out of voluntary ED call. The good news is that with some focus and thought, the ED can show hard and fast improvement results with benefits that also go downstream, if leaders focus on some key areas.

Don’t accept the paradigm

It is too easy to accept that certain ED problems are endemic—that patients will sit around in a waiting room, for example. Often, the solution has been to build more ED beds to handle the volume and reduce wait times rather than seeking out a process redesign that will accomplish the same goal. Scripps Health President and CEO Chris Van Gorder says he got tired of hearing that wait times and patients leaving without being seen was as permanent a fixture in the ED as scrubs.

“I kept spouting that if this was virtually any other industry where we had a significant customer dissatisfied and a roadblock in our system, we would focus all our time and attention and energy on that until we got it fixed,” Van Gorder says.
So the Scripps team undertook a radical review of how ED patients are triaged and treated. Rather than having the same team of nurses and doctors treating acute and non-acute patients with the same team in the same beds, Scripps divided the team so all patients get to the physician without the long wait. And for those who don’t need a bed, a recliner is faster and more patient friendly.

At two hospitals on the new system, wait times from door to physician went from an average of 97 minutes to 29.

**2 | Mercilessly bust silos**

The one department that you can least afford to be in a silo may be the one stuck in it the hardest. Beth Houlaian, RN, senior vice president of patient care services and chief nursing officer of Mercy Medical Center in Cedar Rapids, IA, says not too many years ago “what we had were many siloed departments and our effort has really been on standardizing care and looking at the continuum of care.”

Among the structures Mercy put in place was to bundle operational responsibility for the ED and inpatient side under Houlaian’s authority. Process improvement teams using Lean quickly went to work on bottlenecks that slowed down care and reduced patient satisfaction.

The physician staff of ED specialists and the admitting hospitalists also worked to create a dialogue based on what is best for the patients.
patient at all times, says Mark E. Valliere, MD, senior vice president for medical affairs and chief medical officer. Now if the ED physicians say a patient needs to be admitted, the hospitalists don’t always have to come down to verify that, Valliere says. “It took a little getting used to for the two sides to work together and there’s still the occasional patient that’s kind of borderline where the hospitalists will come down and look at him. But I think that has gone well.”

3 | **Don’t be afraid to make mistakes**

When you need to make big changes, you’ve got to take big chances—and not every idea or program will work out. “We believe in failing while trying versus failing by not trying,” says Michael Young, CEO of Grady Health System. The organization was in danger of closing just three years ago and still faces its share of troubles. But they’ve also attacked a number of problems—from kicking their reliance on agency nurses to embracing electronic medical records. New options for patients—including a planned urgent care center—are helping to ease flow and improve throughput and improve access.

“You have to be willing to try new things, measure it, compare that against the old way, and if it’s better, keep it. If it’s worse, go back to the old way. You can never be worse off than you were before, and you might as well try something better—because it might actually be better.”

4 | **Put out the welcome mat**

Critics say EDs are overcrowded with patients who don’t really need emergency care. Not true, says Cambridge Health Alliance. Every patient who walks through those ED doors needs and deserves care—and they embrace the business impact on their entire system, building business for primary care physicians, specialists, inpatient services, and more. But before the organization could embrace patients, it first had to stop turning them away. Just a few years ago, diversions were routine—even when the ED wasn’t at capacity. “If you’re diverting patients because your emergency room can’t process the volume, you’re actually diverting business to other organizations unless you’re always running at full capacity, which very few hospitals are,” says CEO Dennis Keefe. “Strictly from a business point of view, that doesn’t make any sense.”

The organization redesigned its ED not only to eliminate diversions but also to welcome patients—with patient navigators, a new, more efficient triage process, and drastically lower wait times. All of the changes have added up to more satisfied patients and steady year-over-year growth, he says.

“The turnaround times that have continually declined, the diversions that have been eliminated, the Press Ganey results, waiting times to see the doctor, the waiting time in the treatment area—none of those things would have improved if we had not stayed ahead of the curve in terms of the service,” Keefe says.

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Michael Young, CEO,
Grady Health System
There is a great deal of focus right now on hospital EDs as the front door to the hospital and a gateway to the health system. Highly valued but often underappreciated in the continuum of care, the ED is the source of most hospital admissions, a primary driver of revenue, and possibly a hospital’s most important competitive differentiator in the market. Yet, hospital EDs also are braced for potentially significant changes ahead in patient volume and case mix, further cuts in reimbursement, ongoing financial pressures, and higher expectations from newly empowered consumers.
Some believe that one by-product of health reform can and should be keeping people out of hospital emergency departments by better marshalling primary care resources, bringing healthcare delivery into the community, and focusing on wellness and prevention. Others believe that already overcrowded, understaffed EDs will be even more overwhelmed by the influx of newly covered patients.

Still others have a vision for ED as the hub of highly coordinated, higher-valued care with a central role to play in the move toward more accountable, collaborative, and highly integrated care.

What’s irrefutable is that it is impossible to have a high-performing system without a high-performing ED. The challenge for hospital administrators and CEOs is creating a high-performing hospital ED that adds value from both a business and care standpoint, and which appropriately balances cost allocation and reimbursement with how, where, and which services are delivered to the right patients at the right time.

The performance of the ED is uppermost on the minds of hospitals executives as they strategize their response to regulatory and market forces. Over the years, there have been many incremental improvements in process, workflow, and patient throughput. But...
the most dramatic changes are still to come for the ED as emergency medicine shifts from operating as a provider-centric silo to a highly collaborative, consumer-centric hub for directing patients and coordinating their care among a network of providers focused on patient outcomes.

The highest performing EDs are those that are engaging physicians to understand their roles and the ED as part of a bigger, more collaborative whole. Much of this engagement is focused on innovative compensation arrangements such as physician co-management models and, eventually, accountable care organizations.

The ultimate goal is a long-term partnership between hospitals and physicians, built upon appropriately aligned incentives that enable all stakeholders to share in the risks and rewards of a high-performing, consumer-centric ED that adds value to the health of the community it serves.

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