The Coordinated ED

Case Study | Cambridge Health Alliance

This is CASE STUDY 1 of 4 from HealthLeaders Media Breakthroughs: The Coordinated ED
If you want a quick look at how Cambridge Health Alliance (CHA) runs its emergency department, just take a look at the home page of the organization’s website. There you’ll find wait times for each of its three EDs, updated every 10 minutes. The posted wait time at the Cambridge location—the busiest of the three—is rarely more than five minutes. Wait times at the other two campuses are routinely just two or three minutes.

Those numbers are even more impressive when viewed in combination with the rest of CHA’s stats. The system hasn’t gone on diversions for years. Fewer than 1% of patients leave without being seen. Patient satisfaction scores are up. Volume is up. Staffing levels are flat. And that’s just for starters.

Just a few years ago, diversions were routine—even when the ED wasn’t at capacity. Press Ganey patient satisfaction scores were in the bottom 1%. Each ED had its own processes and systems, which by all accounts weren’t working particularly well. There was a culture of inefficiency—and no real incentives for clinicians and staff to do better.

In response, the organization set “ambitious and sometimes even shocking goals,” says Gerald Steinberg, MD, CHA’s chief medical officer.

One of the first was to eliminate ED diversions. “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.” Similarly, long wait times drive away business and harm an organization’s reputation, he adds.

Focusing on the “front door to the community” can make the entire organization more successful.
"EDs go on diversion not because they want to go on diversion," says Assaad Sayah, MD, chief of emergency medicine. "They go on diversion because nobody listens. When the place is busy and they need help, everybody says 'do it yourself.' It's like you're waging a war by yourself."

In other words, says Keefe, operational inefficiencies were embedded in the culture.

Sayah agrees. "There was a culture ... that it is the patient's privilege for the ED to take care of them and not the other way around. There was really very little attention paid to the patient's experience and patient satisfaction and many other pieces regarding flow and staffing."

Door-to-doctor time, at more than 90 minutes, was one major problem. Patients simply weren't being moved out of the ED and into inpatient beds quickly enough. "You get to a point where ... half of your [ED] beds are occupied by admitted patients. You have little help or assistance in resolving your overcrowding issue. Admitted patients are not moving upstairs. You call the floors upstairs and they say, 'Oh, we just had a change of shift; call us back in an hour,' " Sayah says.

"What are the options? They go with the path of the least resistance. Let's stop the inflow and go on diversion until we get this squared away."

When he first came on board, Sayah told ED staff that they could only go on diversion after giving him 20 minutes to find another solution. So what does Sayah do in those 20 minutes?

"I raise hell," he says. "I page all of the administrators and all the department chiefs and cause all kinds of trouble. I walk into the ED. If there are patients waiting, I see the patients, and if there are patient rooms to be cleaned, I clean the rooms. If there are people to be transported, I recruit somebody and get them transported upstairs or I will move the patient upstairs."

Before he launched what the organization now calls "Code Help" he made sure other administrators backed his plan. "So when I started calling them, they couldn't say, 'Why are you calling me?' "

Suddenly, pressure to move patients through the system was no longer coming from the ED alone. And that cleared the way for other operational changes and efficiencies.

"We wanted all three EDs to run with a single standard of practice, a single standard of care, a single set of goals and accountability," says Allison Bayer, executive vice president and chief operating officer.

So much hinged on the three EDs—community perception and the ability to recruit high-quality physicians, nurses, and ancillary staff, she says. "We committed to implementing technology [to] change the way expectations are set—you get new kinds of information and data coming at folks who have to be able to use it and digest it and share it with teams. We also invested a lot in developing the staff of the emergency department at all levels."

"We reengineered everything in the emergency department," Sayah says, adding that institutionwide support was an essential ingredient for success.
"We started with three EDs, with three different sets of policies, with three different sets of paperwork, with three different sets of equipment. Everything was standardized across the board."

CHA eliminated its sequential intake process: first sending a patient to triage, then registration, and then treatment. "Instead of patients going step by step and doing things one thing at a time, we want to do 10 things at a time in parallel," Sayah says.

Now, when patients first enter the ED, they are greeted with a smile by a "patient partner." Registration consists of three questions: name, Social Security number or date of birth, and chief complaint.

"Those questions are sufficient to do your registration," Sayah says. "We boil down the million questions registration—next of kin, emergency contact, address and insurance, and religion. We pushed the sequence of those questions until after the patients got their care."

After arrival and mini-registration, patients are moved quickly into a room. Clinicians—nurses, physicians, and physician assis-
tants—come to the patient. Staff members conduct a full registration at the bedside, taking advantage of downtime between tests and procedures. “Forty percent of the patients that come through the door during that time do not leave that room. They stay in the same spot and get discharged from the same spot and we go around them,” Sayah says.

Patients who will likely be admitted are identified early in the process so that units have more time to prepare. “What we used to call the waiting room is generally empty,” Steinberg says. In addition, the electronic health system can use that “mini-registration” information to identify the patient’s primary care physician—62% of patients have an in-system doctor—and alert him or her with a page and an e-mail.

One of the major complaints from PCPs was that the ED would only notify them when a patient was admitted. Physicians didn’t get records, images, or other clinical data when a patient was treated and released.

“There’s nothing worse than being a physician and your patient comes and says, ‘Oh, you didn’t know I was in the hospital last night?’” Bayer says. “It’s very embarrassing,” adds Steinberg. “It doesn’t indicate good coordination and handoff and continuity.”

PCPs will often respond to alerts by calling the ED with information that’s critical to the patient’s care. “So we work together right from the beginning. It makes our job easier, too. Because at the end of the day that patient needs to be handed off to their PCP whether the patient gets admitted or they get discharged. Either way, it’s good for us and it’s good for the patient.”

If a patient doesn’t have a primary care physician, the system sends a message to the outpatient clinic closest to the patient’s
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.

To address the compensation issue, the organization raised pay from the 20th percentile to the 40th and implemented an incentive pool in which physicians are rewarded yearly for productivity, patient satisfaction, and citizenship. There’s been a transformation of the culture in the three emergency departments, Steinberg says. “It’s been accomplished by focusing on the care and the patients as opposed to making speeches about culture change. While speeches and pep talks are an important part of transformation and change, ultimately you accomplish things by working together in service to the customer, in this case the patient,” he says.

Source: Cambridge Health Alliance.

ED VISITS AND ADMISSIONS

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