Benchmarks and Best Practices in the Emergency Department

Jeanne McGrayne
Premier Consulting Solutions
Agenda

• How we use benchmarks to improve and sustain performance
• Introduction to tools available
• Share common ED benchmarks
• Discuss best practices that consistently return improved outcomes
Premier Consulting Solutions

Improving Clinical, Operational & Financial Performance

DIAGNOSE
- Business Imperative
- Sponsorship Building
- Benchmarking/Diagnostics
- Interviews & Collaboration
- Opportunity Identification & Quantification
- Initial Transformation Agenda

IMPROVE
- Accelerated Solutions Development:
  - Transformation Agenda Validation & Prioritization
  - Execution Plan Development
  - Work Team ID
  - Charters & Workplan Development
  - Implementation & Execution

MEASURE
- Performance & Realization Tracking
  - KPI’s
  - Scorecards
  - Monthly Stoplight Management Reporting

COMMUNICATE
- Budget Neutrality
- Continuous Improvement

SUSTAIN
Trends and Issues in Emergency Care

- It’s all about the Economy
  - Patients
  - Staff
  - Physicians
  - Payers
- Increasing regulatory pressure
- What does it mean for ED Operations?
Finding Balance in ED Operations

Resources: Rooms/Staff

Length of Stay

Volume
Why Benchmark?

- To set goals
- To find peer organizations
- To discover better performing organizations
- To identify practices which result in better outcomes
Key Data Sources for Benchmarking ED Performance

• **Premier Emergency Department Benchmarking Database**
  - 90+ hospitals
  - Free (Except time required to complete the ED Survey)
  - Excel based

• **Operations Advisor™**
  - 600+ hospitals
  - Labor and supply outcomes

• **Clinical Advisor™**
  - Physician performance
  - Clinical performance
  - Financial performance
  - Compliance
Emergency Department Patient Flow Processes

Door to Doctor

- Arrival Patterns
- EMS volume
- Triage Staffing and Processes
- Registration
- Patient Placement
- “Fast Track” assignment
- ED Capacity = Rooms/Staff X LOS

Doctor to Disposition

- Information System Functionality
- RN/MD/Staffing/Ratios/Skill mix
- RN/MD Room Assignment
- Diagnostic Testing
- Support
- Protocol Use
- Team work

Disposition to Discharge/Admit

- Consultant/Hospitalist Response
- Incentives
- Cash Collections
- Consultant/Hospitalist Practice
- IP Bed Availability
- IP Nurse Staffing
Emergency Department Patient Flow Data

Door to Doctor
- Volumes
- Acuity/Admission %
- Arrival Patterns
- Payer Mix
- Left Without Being Seen/Diversion
- EMS TAT
- Door to Triage
- Triage Times
- Triage to Bed
- ED Visits per Bed

Doctor to Disposition
- Bed to MD in Room
- MD to Order Entry
- Order Entry to Result
- ED Worked Hours/Visit
- Patients per Provider (MD/PA/NP) Staffed Hour
- Utilization Statistics
- Consultant/Hospitalist Response times
- Quality Indicators

Disposition to Discharge/Admit
- Discharge Order to Patient D/C
- Admit Order to IP
- Bed Assigned
- IP Bed Assigned to IP Bed Ready
- Bed Ready to Patient in IP Bed
Payer Mix

ED Payer Mix

- Self Pay: 21%
- Medicaid: 18%
- Medicare: 19%
- Workers Compensation: 2%
- HMO: 11%
- Commercial: 22%
- Medicaid: 18%

Self Pay: 21%
Medicaid: 18%
Medicare: 19%
Workers Compensation: 2%
HMO: 11%
Commercial: 22%
Triage Acuity

Triage Acuity - 5 Level System

- Level 1: 6%
- Level 2: 19%
- Level 3: 38%
- Level 4: 27%
- Level 5: 10%

Triage Acuity - 3 Level System

- Emergent: 9%
- Urgent: 39%
- Non-Urgent: 52%
ED Admission Activity

**Percent of ED Patients who are Admitted**

- Minimum: 7.5%
- Median: 17.6%
- Quartile: 14.0%
- Average: 18.2%
- Maximum: 32.0%

**Percent of Inpatient Admissions Originating in ED**

- Minimum: 16%
- Median: 54%
- Quartile: 44%
- Average: 54%
- Maximum: 90%
ED Quality Indicators

### ED Quality Indicators

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<th>Median</th>
<th>Quartile</th>
<th>Average</th>
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<td>1.90%</td>
<td>0.80%</td>
<td>2.20%</td>
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<td>0.69%</td>
<td>0.37%</td>
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<td>48 Hour Returns</td>
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Door to Bed Time

Door to Bed

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Minutes
Bed to Doctor Benchmarks

Bed to Doctor

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<td>30.3</td>
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Minutes
Bed to Doctor Benchmarks

Average Physician to Extender Ratio: 2.5 : 1
Average time the ED Medical Director involved in Administrative activities: 36%
Doctor to Disposition Benchmarks

Doctor to Disposition

<table>
<thead>
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<td>Median</td>
<td>152</td>
<td>101</td>
<td>53</td>
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Minutes
Disposition to Depart Benchmarks

Disposition to Depart

Overall
Fast Track
Discharged
Admitted

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<tr>
<td>Quartile</td>
<td>84.4</td>
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<td>11.9</td>
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<tr>
<td>Median</td>
<td>144</td>
<td>32</td>
<td>23.5</td>
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Minutes
Overall Length of Stay Benchmarks

Length of Stay from Arrival to Depart

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<th>Fast Track</th>
<th>Overall</th>
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Minutes
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<th>Worked FTEs</th>
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<th>Total Paid Hrs/Unit</th>
<th>Benefit %</th>
<th>Overtime %</th>
<th>Labor Exp/Unit</th>
<th>Supply Exp/Unit</th>
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<td>7.07%</td>
<td>$123.68</td>
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<td>3,382</td>
<td>57.24</td>
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<td>$77.93</td>
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Emergency Department

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<tr>
<td>Clerical</td>
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Percentage of Paid FTEs
“Door to Doctor” Best Practices

- Quick Registration
- Brief triage assessment (but not too brief)
- Triage Nurse assigns room
- Active Use of Acuity/Status Column
- ED Tech escorts patient to room
- Beds are made available
- “Fast Track” criteria flexible
- Staff “Pull” patients when triage times excessive
- ED patient tracking system
- Aligned ED Physician Incentives
“Doctor to Disposition” Best Practices

• “Free” Charge Nurse able to focus on moving patients out of ED
• Nurses pre-assigned to rooms
• Physicians pre-assigned to rooms
• Teamwork!!
• Reduced Variation (room set up, practice, protocols)
• Protocols so that expected care is anticipated
• Rapid laboratory turnaround times
• Appropriate amount of point of care testing
• Dedicated ED radiology staff and rapid 2D interpretations
“Disposition to Discharge” Best Practices

• Measuring and monitoring disposition order to time of discharge by nurse.
• Discharge planning begins on admission
• Case Management/Social workers staffed in ED
• Smooth collections process
• Automated discharge instructions initiated by the physician and reviewed by the RN with the patient
Reduce Process Variability Through Accountability and Communication

- Sharing data leads to self correcting performance and reduces variability.
In-Patient Throughput Processes

1. Decision to Admit to Orders Written
   - Consultant/Hospitalist Availability and Response
   - Pathways/Order Sets
   - Trust between Admitting MD and ED Physicians

2. Order Written to Bed Assignment
   - Responsibility/Authority for Bed Control
   - Bed Tracking
   - Hospital Capacity = Rooms/Staff X LOS
   - Critical Care/Telemetry Use
   - Diagnostic Testing
   - Support/Availability
   - Case Management
   - MD Rounding Patterns
   - Surgical Scheduling
   - Discharge Practices
   - Housekeeping Support

3. Bed Assignment to Time in Bed
   - Report and Communication
   - Shift Change Practices
   - Transportation
   - RN Staffing/Ratios
   - Discharge Unit
Disposition to Admit Best Practices

• Aligned Physician Incentives; Hospitalist contract
• Bed Tracking systems/Transparency
• Surgical Schedule “Smoothing”
• Private Rooms; Telemetry/Oxymetry Availability
• Bed Control under Case Management
• “No refusal” Policy
• Bed Management Assigns Bed, Independent of Nurse Staffing
• Housekeeping and Transport Services dedicated to Bed Management
• Receiving Nurse has time limit from bed assignment in which to call ED for Report (Pull)
• Fax Report; Bedside Report
Questions?

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