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MAY 2013

ED Solutions:

Preparing for Increased Volume and Decreased Margins

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About the Premium and Buying Power Editions

This is a summary of the Premium edition of the May 2013 HealthLeaders Media Intelligence Report, *ED Solutions: Preparing for Increased Volume and Decreased Margins*. In the full report, you'll find a wealth of additional information, including the results of all the survey questions. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (i.e., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions.

- A Foreword by Leon L. Haley Jr., MD, MHSA, CPE, FACEP, Deputy Senior Vice President for Medical Affairs and Chief of Emergency Medicine, Grady Health System, Atlanta, and the Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Bon Secours Health System, Inc., in Marriottsville, Md.; Cambridge (Mass.) Health Alliance; and Grady Health System in Atlanta
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

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Locked items are available in the Premium and Buying Power editions.

Methodology

The *ED Strategies Survey* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In February 2013, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 282 completed surveys are included in the analysis. The margin of error for a sample size of 282 is +/-5.8% at the 95% confidence interval.

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The following healthcare leaders graciously provided guidance and insight in the creation of this report.

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Upcoming Intelligence Report Topics

JUNE: ***Service Line Strategies***

JULY: ***Patient Quality & Safety***

AUGUST: ***Patient Experience***

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

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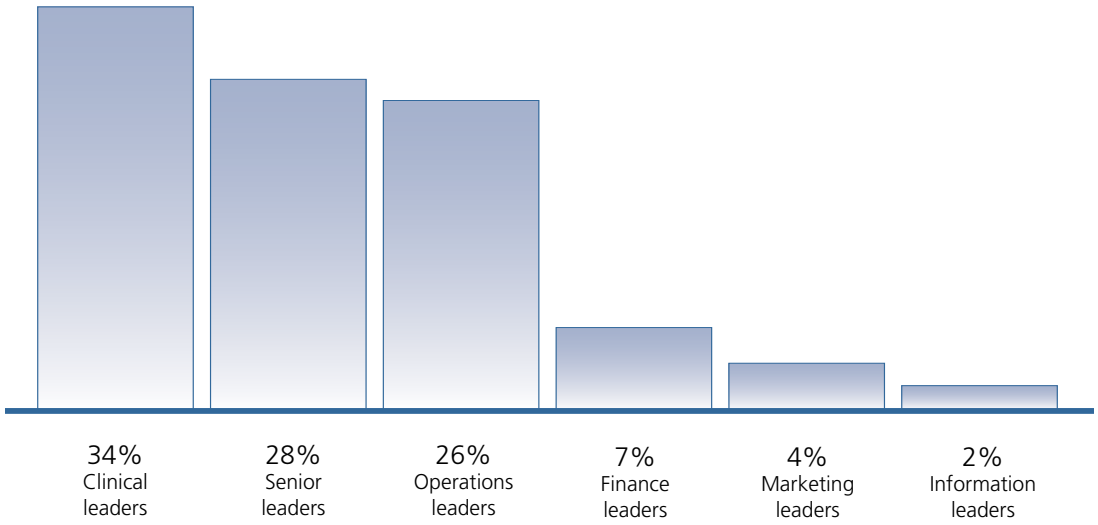
Respondent Profile

Respondents represent titles from across the various functions at hospitals and health systems.

Title

Base = 282



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/ Administration, Other VP

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Finance leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Type of organization

Base = 282

Hospital	68%
Health system	32%

Number of beds

Base = 192 (Hospitals)

1–199	46%
200–499	40%
500+	14%

Number of sites

Base = 90 (Health systems)

1–5	36%
6–20	32%
21+	32%

ANALYSIS

Healthcare Leaders Look to Efficiencies Inside and Outside the ED

MARGARET DICK TOCKNELL

The emergency department continues to be challenged by its own internal problems even as it seeks to work with other hospital departments to overcome bottlenecks that can affect the efficiency and quality of patient care.

The results of the *2013 HealthLeaders Media Emergency Department Survey* show that resolving these issues will remain an uphill battle as demand for ED services increases, quality metrics draw public attention, and ED overcrowding raises patient safety concerns. Reimbursement challenges and declining operating margins will further complicate matters.

For many, the ED is the de facto front door to the healthcare delivery system. The one-stop shop can be an attractive option compared to taking several days for patients to visit physicians, get tests performed, and obtain the results. "What else is open that meets people's lifestyles?" asks Allen Rinehart, director of the ED at the 345-bed Carle Foundation Hospital in Urbana, Ill. "A lot of people work different hours and sleep during regular business and physician office hours. They can come to the ED with abdominal pains at 11 p.m. In one trip they can get lab work, a sonogram, and find out if they need surgery or just medications. That all happens within a six-hour stay instead of over several days and several different doctor appointments."

WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments from leaders concerning steps they expect to take regarding their ED's approach to the continuum of care.

"We keep treat-and-release patients out of an ED bed; we put in lounge chairs. We have a family nurse practitioner carefully work on discharge and follow-up plans."

—CEO of a medium health system

"We will further implement our EHR to improve communication with the primary care physicians."

—Chief medical officer of a medium health system

"We will focus on better patient flow, expediting the admission process, and improving patient record information sharing."

—Chief nursing officer of a medium hospital

"We will focus on a system to address 30-day readmissions and frequent fliers. We expect opioid-seeking behaviors to increase as abusable drugs go off patent."

—CEO of a medium health system

"We're working on changing how triage operates and doing immediate bed placement from the waiting room."

—Director of clinical services of a medium hospital

"We are renovating and expanding the ED and have also hired a new physician group to manage the ED and improve our quality outcomes and patient satisfaction."

—Vice president of marketing of a small health system

Analysis (continued)

Even as the healthcare industry transitions its delivery systems to emphasize patient-centered medical homes, care coordination, and the continuum of care, almost nine in 10 healthcare leaders (86%) expect their ED volumes to increase within the next three years.

It seems counterintuitive that demand for ED services is projected to grow just as millions of newly insured will enter the healthcare marketplace, but that has been the experience in Massachusetts where, in 2006, the state adopted a healthcare reform system that requires all residents to carry a minimum level of healthcare insurance. Since then, ED volume across the state has "increased by about 1.5% annually," according to Assaad Sayah, MD, chief of emergency medicine at the three-hospital Cambridge Health Alliance in Massachusetts. He notes that his own ED recorded 77,000 patients in 2005 (before Massachusetts healthcare reform), 98,000 in 2012, and is on track for 100,000 patient visits in 2013.

Sayah says physician shortages, especially in primary care, fuel much of the ED demand. "With healthcare reform, although the solution is to provide coverage for patients, the true solution is that there needs to be more patient access to primary care."

Overcrowding

As demand for ED services increases, more healthcare leaders describe their EDs as overcrowded. While 46% of respondents described their ED as being overcrowded in our 2012 ED survey, 61% do so in this year's survey. Overcrowding exacerbates some common ED challenges. About one-third of respondents (32%) said patient flow is the greatest challenge facing their ED, wait time was mentioned by 15%, and patient boarding by 13%.

> "The true solution is that there needs to be more patient access to primary care."
>
> —Assaad Sayah, MD, Chief of Emergency Medicine and Medical Staff President, Cambridge (Mass.) Health Alliance

Survey respondents cite a number of effective ED operations techniques to improve ED throughput: fast-track area for lower acuity (61%), triage medical evaluation process (58%), and streamlined registration process (53%).

The fast-track area at Brookdale University Hospital and Medical Center in Brooklyn, N.Y., is a separate treatment area for patients with minor illnesses and injuries, and small lacerations. It is open 24/7, provides care for about 25,000 patient visits annually, and helps relieve congestion in the main ED, which receives about 100,000 visits each year. Lewis W. Marshall Jr., MD, JD, chairman of emergency medicine for Brookdale, says the facility has added staff to enable it to serve 100 patients per day in the fast-track area.

Analysis (continued)

Cambridge Health Alliance improved patient flow by reducing registration to a one-minute, three-question process.

Systemwide issues also cause headaches for the ED. "The ED only flows as well as the hospital flows," says Leon L. Haley, MD, deputy senior vice president of medical affairs and chief of emergency medicine at Grady Health System in Atlanta. "On some level, we've done ourselves a disservice by talking about ED overcrowding. We should be talking about hospital crowding and hospital flow."

Depending on the ED issue at hand, Haley says the throughput committee at Grady might consider environmental services staffing and room cleaning, radiology department staffing and testing hours, physician staffing, lab processes and structure, and possibly guest services and transportation. "It's all tied together," he says.

George Couch, vice president of the 276-bed Wheeling (W.Va.) Hospital, says the hospital looks at every process connected to the ED to identify roadblocks that might hinder the hospital's ability to quickly serve its ED patients. He explains that two relatively simple steps helped cut in half the time needed to get radiology studies returned to ED physicians. It seems that digital images sent to radiology were placed in a queue of ED, inpatient, and outpatient images without any priority. That's been changed, and now the ED receives priority. "We also worked to coordinate transcription staffing with the work demands of the radiologists," says Couch.

Bottleneck

About three-quarters of healthcare leaders (73%) identified ED-to-inpatient transfers as the biggest bottleneck for ED flow. "Keep in mind that every time you delay a discharge upstairs for an hour, it backs up in the course of the day and can be a two- or three-hour delay for the ED," says Marlon Priest, MD, executive vice president and chief medical officer for Marriottsville, Md.–based Bon Secours Health System, a 19-hospital system that serves seven states.

> "We should be talking about hospital crowding and hospital flow."
>
> —Leon L. Haley Jr., MD, MHSA, CPE, FACEP, Deputy Senior Vice President for Medical Affairs, Chief of Emergency Medicine, Grady Health System, Atlanta

Couch notes that working on maintaining hospital discharges by late morning is critical so inpatient rooms can be prepared for the next patient. Late morning is when ED admissions and returns from the operating rooms begin to pick up. His hospital is looking at a number of factors that may impact timely discharges and admissions, including the lab process and structure. "We're working to improve lab turnaround times."

Analysis (continued)

About four years ago, the average ED medical-surgical patient waited seven hours for an inpatient bed at Carle Foundation Hospital. Rinehart explains that a focus on the throughput and admissions process helped reduce the average wait time to fewer than four hours. About 40 patients each day are admitted to the hospital from the ED, so reducing the wait time has opened up "a lot of bed hours for new ED patients" and thus reduced opportunities for the ED to become overcrowded.

Protocols

Less than half of the survey respondents (44%) identified standardized handoff protocols as a method they are using to increase ED throughput efficiency. That surprised Priest. "Much of the stuff that goes into the ED has pretty standard complaints. If you could figure out how to use predetermined evaluations, you could often have lab tests or x-rays done before the patient gets to the main ED area." He suggests placing a physician or a nurse practitioner in a triage area to take brief patient histories and order diagnostic tests according to protocol. The protocols can "help reduce wait time between triage to ED room, to ED physician, to test area, and to test back."

Still, Sayah cautions that these techniques are only a part of the solution. "Those things work, but they don't work by themselves. They've been used for years and yet here we are today with overcrowding and long waits. What's missing? The ultimate solution needs to be a hospitalwide commitment to relieving the ED from being overcrowded, which includes rapid admission and rapid throughput."

Boarding patients on the floor where they will be admitted (when a room is available) may be one effective approach. Marshall says hospitals that have implemented this system report that the patients are happy to be out of the ED and on a floor where they have access to inpatient services from physicians and nurses.

> "Every time you delay a discharge upstairs for an hour, it backs up in the course of the day and can be a two- or three-hour delay for the ED."
>
> —Marlon Priest, MD, Executive Vice President and Chief Medical Officer, Bon Secours Health System, Inc., Marriottsville, Md.

Also important, says Sayah, is to get a C-suite commitment to help with immediate, one-off solutions. When all else fails, even in the middle of the night, the ED needs to be able to turn to the "three or four people within the hospital with the authority to escalate processes across the entire hospital system."

Staffing

Half of the healthcare leaders (50%) identified better nurse workload balancing as the most effective staffing technique to increase ED

Analysis (continued)

throughput efficiency. This response reinforces the systemic relationship the ED has with other hospital departments and functions.

Wheeling Hospital uses electronic scheduling to try to make sure that the right staff is in the right numbers at the right time. The electronic bed-tracking system includes a real-time count of ED patients and their status, including arrivals and discharges, the status of diagnostic tests, and who is awaiting hospital admission. Staff throughout the hospital can review the information to manage flow. Housekeeping staff know when a bed empties and the ED knows when a bed is ready.

Safety

Overcrowding is a huge concern when it comes to patient safety in the ED. Some 96% of healthcare leaders with an overcrowded ED are either "concerned" (45%) or "very concerned" (51%) with patient safety as a result of that overcrowding, which can cause delays in treatment, reduce the quality of care received, and increase the risks for some patients.

This year the Centers for Medicare & Medicaid Services began collecting and posting on its Hospital Compare site several measures of ED throughput information for individual hospitals that volunteered to submit the data, including average wait times to see a physician, average time spent in the ED until discharge, and the average wait time for ED-to-hospital admissions. The reporting measures are expected to evolve into a pay-for-performance program.

As they work toward ED improvements, healthcare leaders are keeping a watchful eye on finances.

> "The ultimate solution needs to be a hospitalwide commitment to relieving the ED from being overcrowded."
>
> —Assaad Sayah, MD, Chief of Emergency Medicine and Medical Staff President, Cambridge (Mass.) Health Alliance

Rinehart says patient mix and local economic conditions will be key influencers. He notes that Urbana is home to the University of Illinois, and its 40,000 students, as well as its staff, are insured. About 51% of his hospital's patient mix is insured and area unemployment is low. "We're on solid ground with our ED. It makes money."

Indeed, a plurality of survey respondents (44%) report that their ED has a positive operating margin. Still, one in five (18%) reports a negative ED operating margin, and 60% say they expect their ED operating margin to decrease within the next three years; only 9% expect increased ED operating margin. In addition, 65% expect ED reimbursement rates

Analysis (continued)

to decrease within the same time frame, and 58% expect an increase in uninsured/self-pay patients.

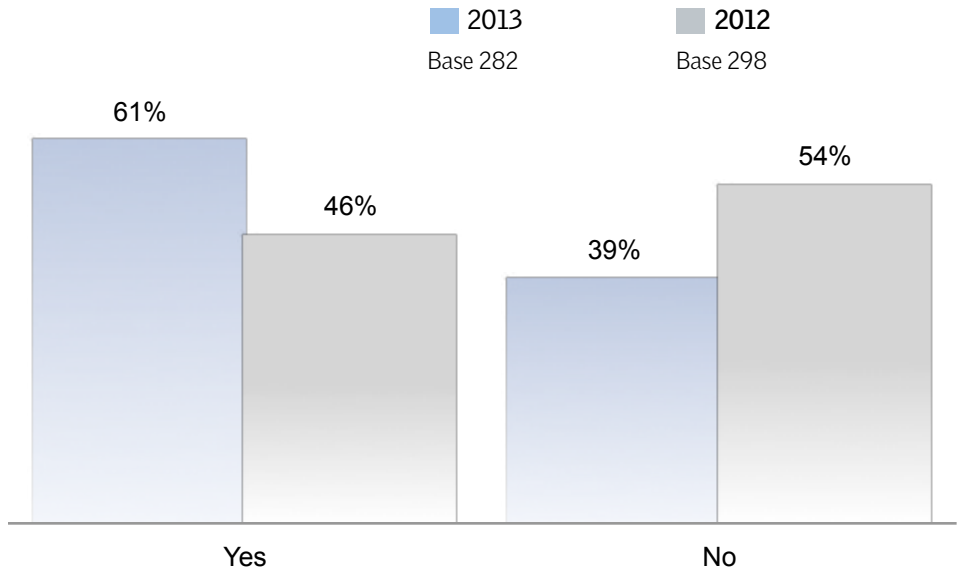
As the industry continues its transition from volume to value, hospital EDs will be affected by both national and local factors, and leaders will need to address clinical and operational concerns not only within the emergency department itself, but also throughout the organization and the continuum of care.

Margaret Dick Tocknell is health plans editor for HealthLeaders Media. She may be contacted at *mtocknell@healthleadersmedia.com*.

FIGURE 1 | Overcrowded ED

Q | Is your ED overcrowded?

TRENDING DATA



TAKEAWAYS

- More health systems (74%) than hospitals (55%) report that their ED is overcrowded.
- Small hospitals (fewer than 200 beds) are more likely to report that they are not overcrowded (62%) than medium hospitals (36%) or hospitals with more than 500 beds (12%).
- Size is less of a factor among health systems, where 81% of small systems (1–5 sites) and 79% of large systems (21 or more sites) report overcrowded EDs. The percentage was lower (62%) among medium systems.

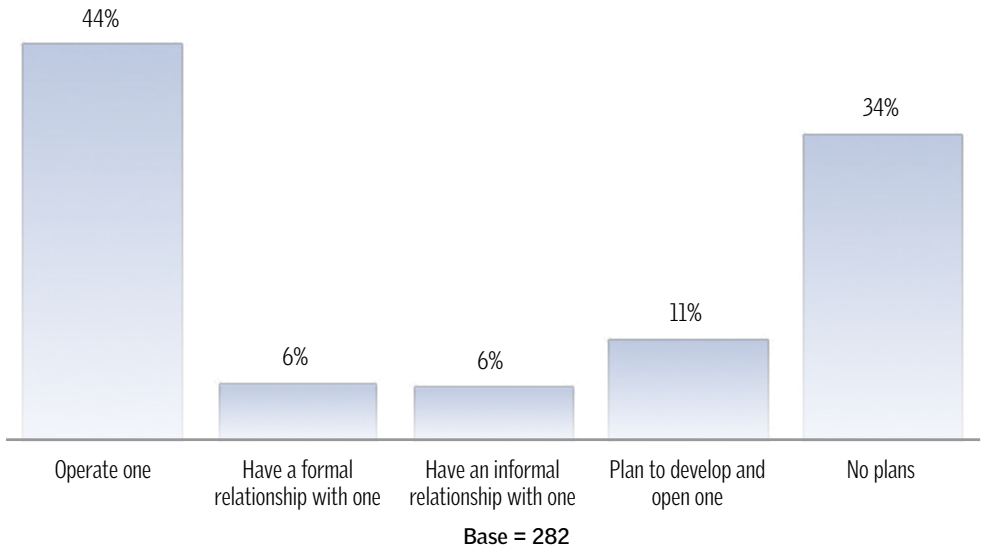
WHAT DOES IT MEAN?

An overcrowded ED can have many causes and may reflect throughput problems within the hospital environment as a whole rather than simply shortcomings or challenges within the ED itself. Size of the facility, geographic setting, the scope of services offered, and the patient acuity mix can each affect overcrowding.

FIGURE 4 | Strategy for Urban Care Centers

Q | Describe your organization's strategy regarding urgent care centers.

Total responses



TAKEAWAYS

- Some 50% of respondents either operate their own urgent care center or have a formal relationship with one.
- By a two-to-one margin, health systems are more likely than hospitals to operate an urgent care center (66% vs. 33%).
- Almost half (42%) of hospitals report that they have no plans for urgent care centers vs. 17% of health systems.
- While Midwest organizations are most likely to operate an urgent care center (58%), those in the South are least likely (32%). Northeastern (16%) and Southern (17%) organizations are most aggressive with plans to develop such centers.

WHAT DOES IT MEAN?

Urgent care centers can ease ED congestion by providing an alternative care setting for patients who seek immediate treatment for minor ailments such as colds and the flu. In addition, the centers can serve as brand extenders in areas where a hospital or health system wants to have an additional presence. In most cases, they are less expensive to develop and operate than EDs because they don't require the same staffing, equipment, or extended hours.

FIGURE 4 *(continued)* | Strategy for Urgent Care Centers

Q | Describe your organization's strategy regarding urgent care centers.

Click on these icons to dig deeper

BUYING POWER Who controls the money?

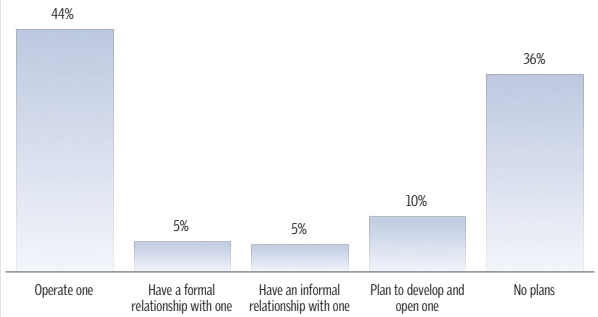
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

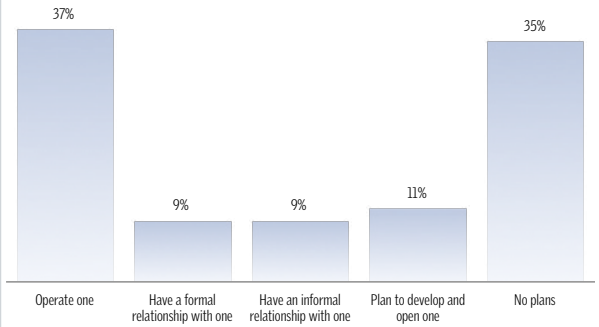
VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

PRODUCTS/SERVICES

Clinical products



Financial services



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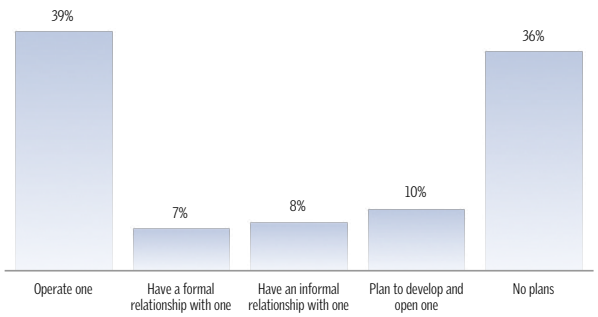
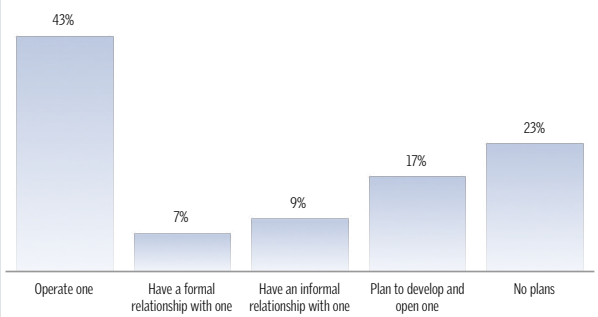
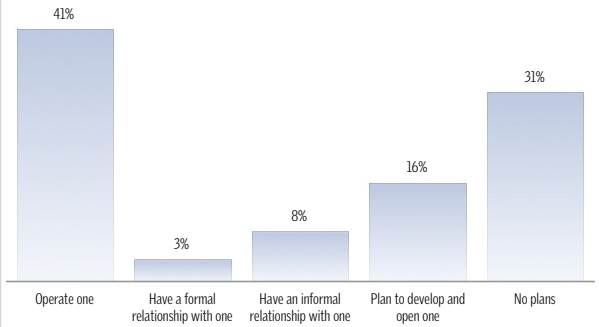


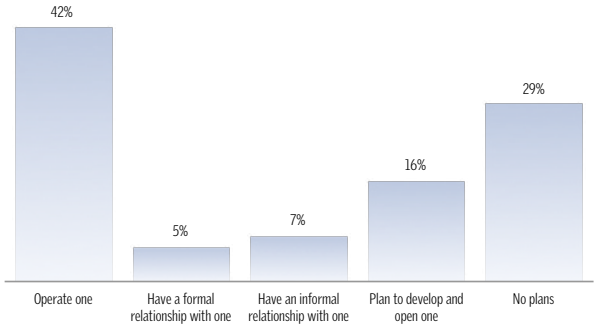
Consulting services



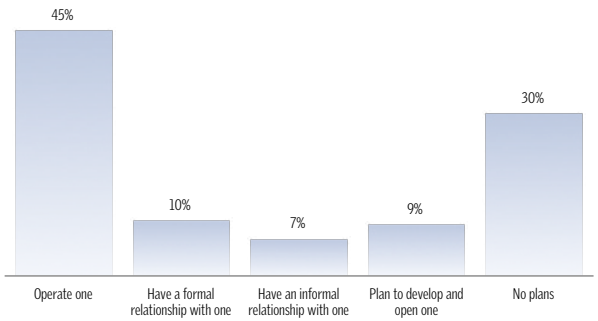
Outsourcing services



Legal services



Information technology



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