

# Transforming the ED Patient Experience: Building in change

## *MA Hospital Lean Network*

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# Objectives

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- To learn about the Emergency Department front-end redesign: there is more to this change than construction
- To explore the principles of change management as they apply to change in the BWH Emergency Department
- To discover the key change concepts that can be applied to other organizational initiatives

# We are facing similar challenges to other EDs, and we are employing similar methods to make improvements

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ABC News July 2010: Fast Treatment Rare in Emergency Departments, Survey Says. While ERs in Some States Improve, Others Leave Patients Waiting Eight Hours or More

- “The AHA reports that **69% of urban hospital EDs...are operating at or over capacity**. Wait times to being treated by a physician has the most powerful association with satisfaction.”<sup>1</sup>
- “The **need for improvement** in emergency departments (EDs) with respect to the cost of care, the speed of service, crowding, and patient safety is now widely accepted. In an attempt to achieve broad improvement, health care organizations worldwide increasingly adopt an approach called “**lean thinking**.”<sup>2</sup>

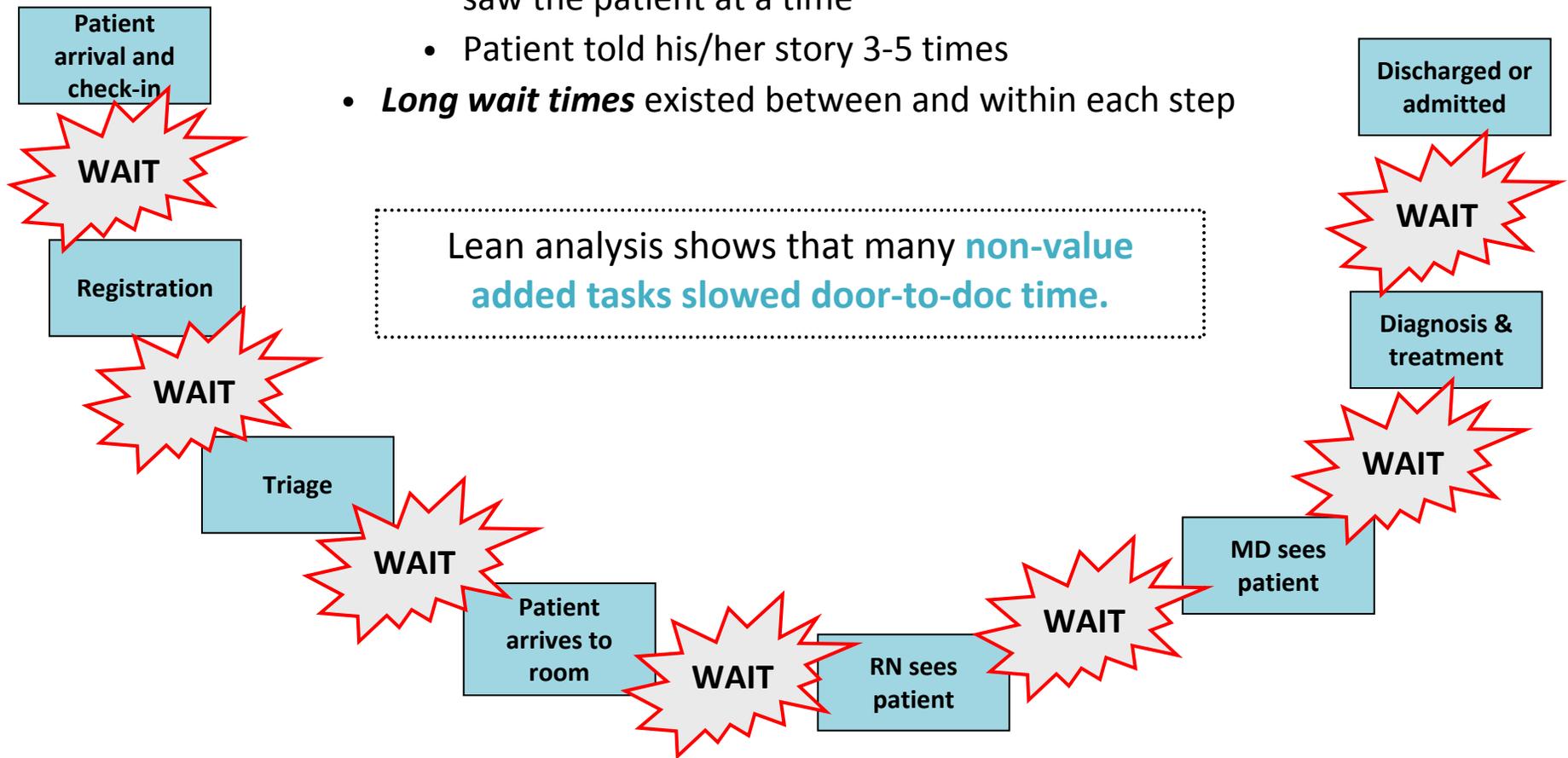
<sup>1</sup> *Optimizing Emergency Department Front-End Operations*, Annals of Emergency Medicine, Volume 55, No. 2, February 2010

<sup>2</sup> *Lean Thinking in Emergency Departments: A Critical Review*, Annals of Emergency Medicine, Volume 57, No. 3, March 2011

# The traditional journey through the ED

The traditional process – which occurred daily and affected all patients – included:

- **Serial processing**
  - Providers worked individually; only one provider saw the patient at a time
  - Patient told his/her story 3-5 times
- **Long wait times** existed between and within each step



# Drivers for change

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**Low patient satisfaction**

**ED overcrowding**

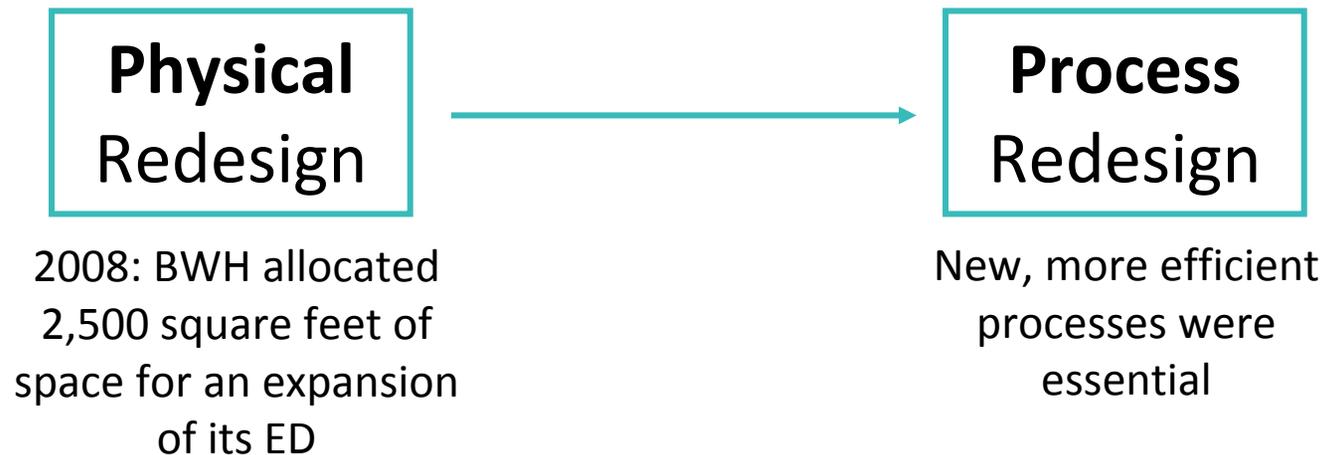
**Imperative to improve access**

**Structural, process and cultural changes**

***A new status quo: VIP care for all patients***

# Vision: Improve the patient experience by eliminating non-value added wait time

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**Transform waiting room space into clinical care space, and the physical setting would support and enhance the re-engineered process.**

# Measuring success: redesign metrics

Goal	Baseline (FY09)
Reduce ALOS	5.0 hours ( <i>overall</i> )
Improve “door-to-doc” time	70 min ( <i>average waiting room time</i> )
Reduce walkouts	3.3%
Improve patient satisfaction	Ranged between 6 <sup>th</sup> and 40 <sup>th</sup> percentiles*
Increase volume	57,532 ( <i>FY09</i> )

*\*among Level I trauma centers with 30K+ visits annually*



# Starting assumptions for the change process

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- Strong leadership support and involvement is essential
- Front line staff must be involved from the beginning
  - Buy-in and a sense of ownership is critical to successful and sustainable change
- We can only change that over which we have control
  - We will focus efforts on input and throughput; output requires a hospital-wide effort
- Lean concepts can help us make necessary improvements

# Six key components of the redesign addressed using “Lean” concepts

Focus Area	Lean Concept
Process improvement	<b>Patient-centered focus</b> <i>(Design a system around the most valued components)</i>
Registration	<b>Check-in at arrival; full registration at bedside</b> <i>(Prioritize “value enabling” steps)</i>
Triage/waiting room	<b>Eliminate steps when a bed is available</b> <i>(Remove “non-value added” steps)</i>
Pod capabilities	<b>Any patient in any pod - patient can go to the next available bed</b> <i>(Standardize processes)</i>
Team assignment	<b>“A bed ahead” – team always prepared to take the next arriving patient</b> <i>(Promote continuous flow)</i>
Oversight	<b>Flow manager role</b> <i>(Provide real-time response)</i>

# The ED redesign process has been phased

## DESIGN THE NEW PROCESS

### WORK-OUTs

March – September 2010

All-day events at which ED staff worked together to design the new ED processes.

Role of flow manager

Patient transfer to pod

Team-based care

### TABLE TOPs

Summer 2009, April – Dec. 2010

Patient flow simulations

Informal simulations

Formal simulation

## VALIDATE THE NEW PROCESS

### Testing / Implementation

November 2010 – Oct 2011

Weekly testing, then daily testing, of process segments

2010

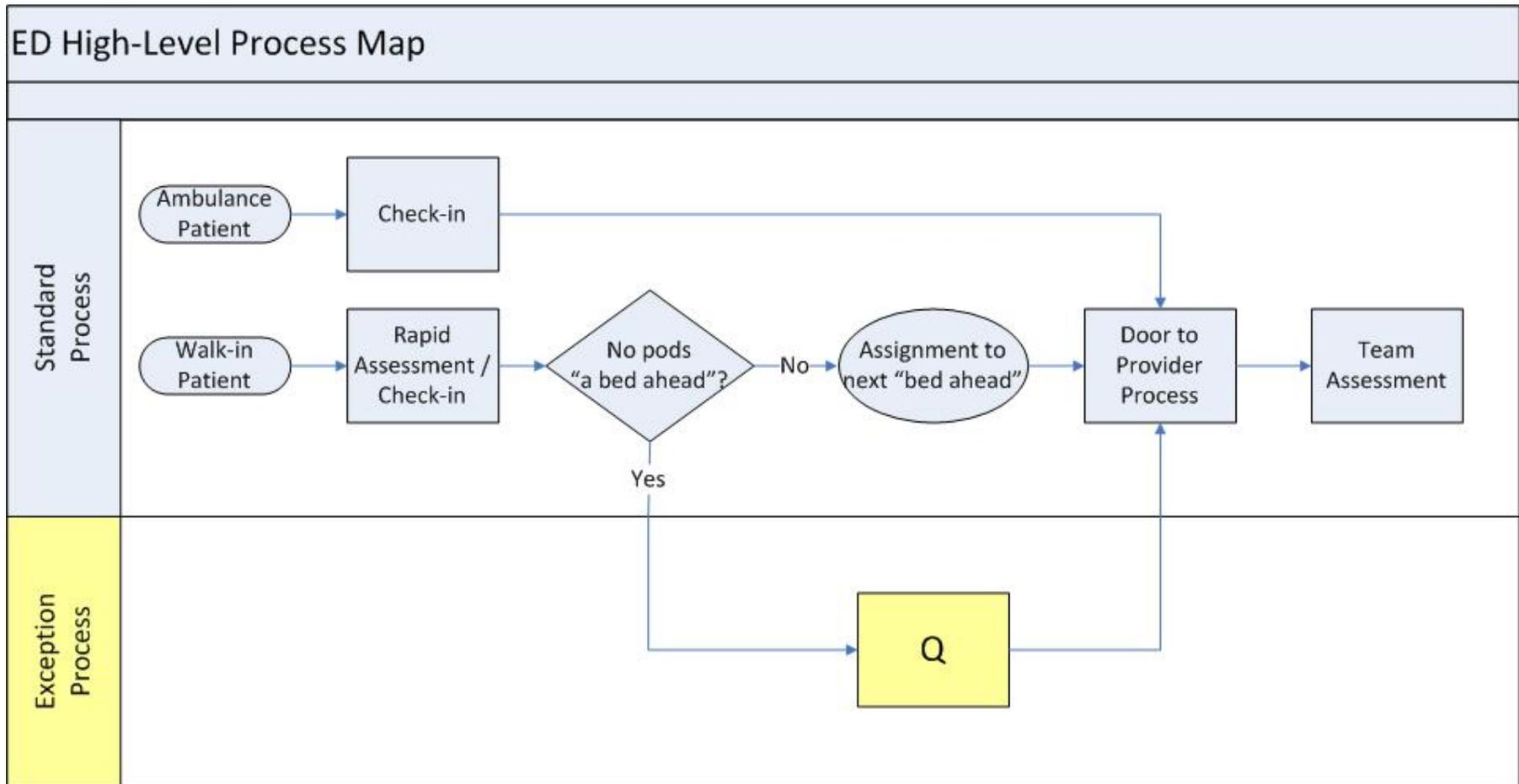
2010 - 2011



# Table-top sessions



# The staff designed the future state process, which would be tested in segments



# A team was created to test the new processes; Result: increased staff buy-in

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**Team Composition:** 1 NIC, 2 MDs, 1PA, 1 ESA, 4 RNs, 1 Resident

## **Test Team objectives:**

- Prioritize and sequence individual tests
- Design tests using formal testing model (**PDSA**)
- Collect data, analyze what worked well and what did not
- Update and confirm future state standard work following testing

## **Test Team committed to:**

- Giving each test a real try – keeping an open mind
- Communicating with peers about the tests
- Helping staff to develop ownership of the processes
- Continuous improvement: testing and re-testing as necessary

# A team was created to implement the new processes; Result: increased staff buy-in and sustain the changes

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**Team Composition:** 2 NIC, 1-2 MDs, 4 RNs, 1 Resident, 1 Educator, Flow Manager

## **Implementation Team objectives:**

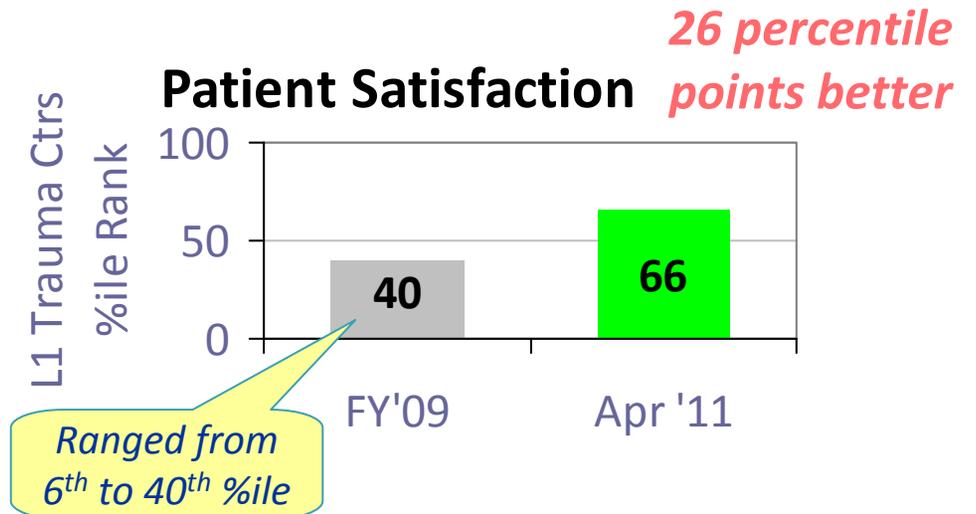
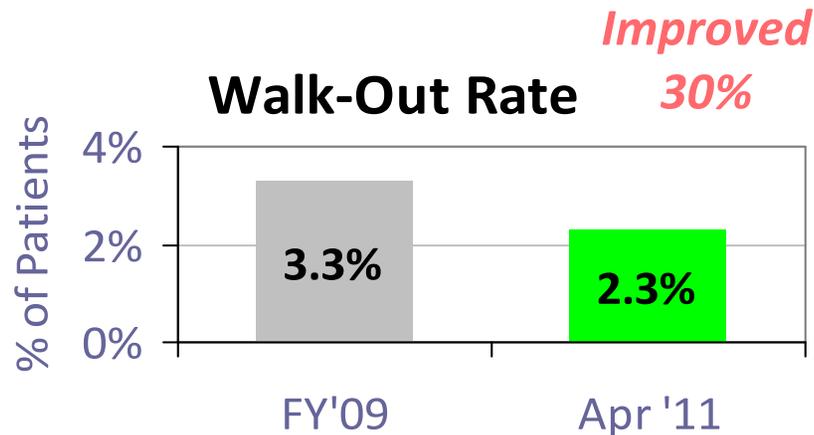
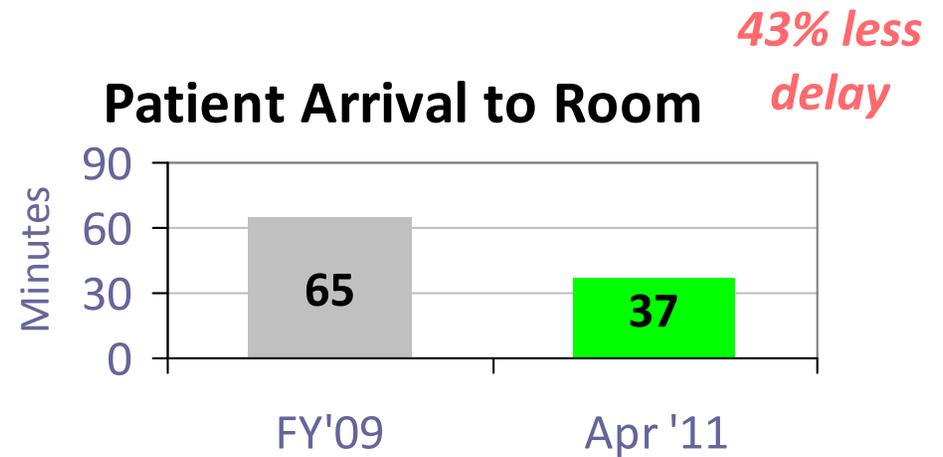
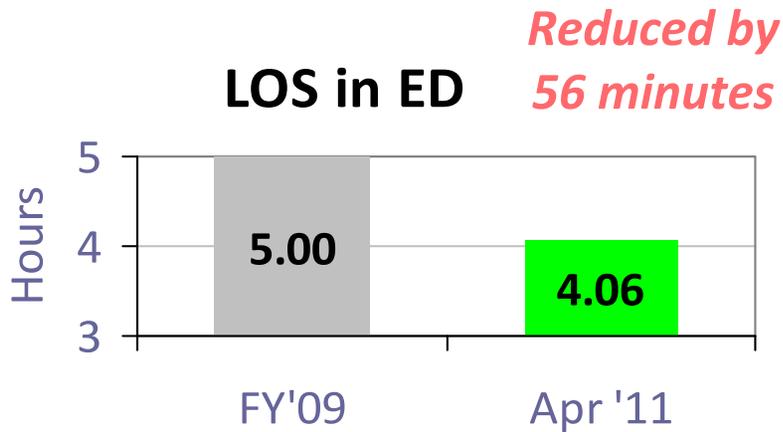
- Continue to standardize roles and expectations for the redesigned process
- Hardwire the changes by supporting the team decisions
- Lead by example

## **Team committed to:**

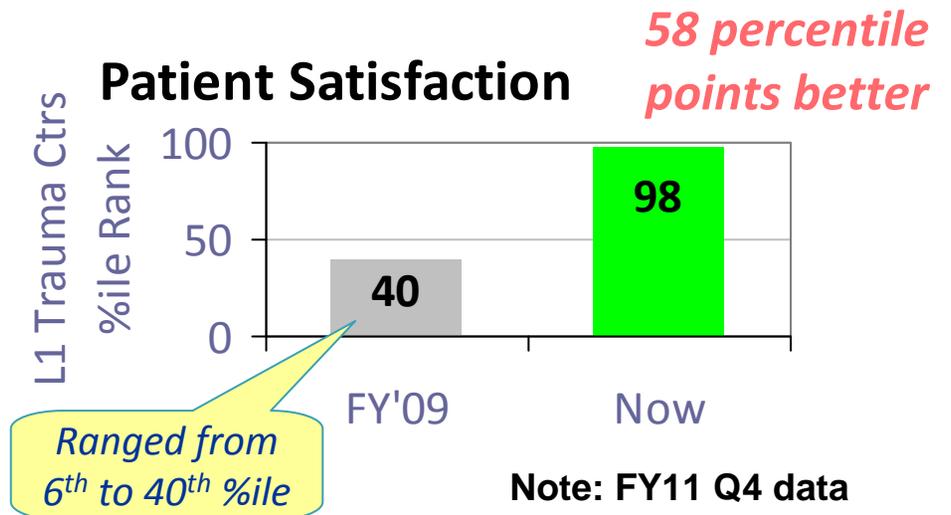
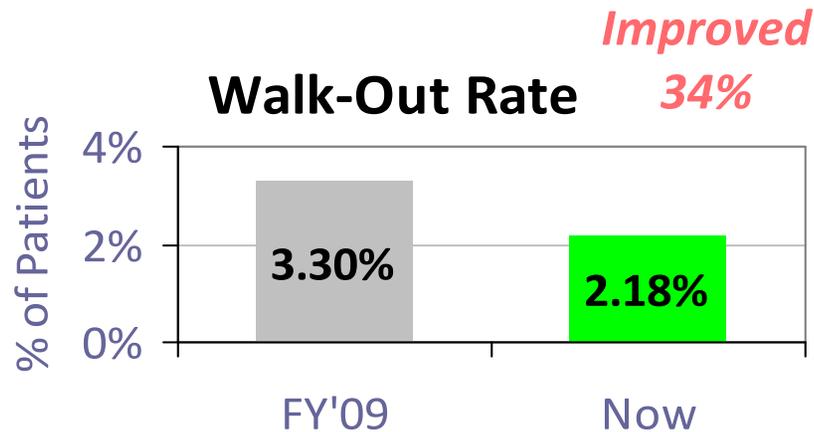
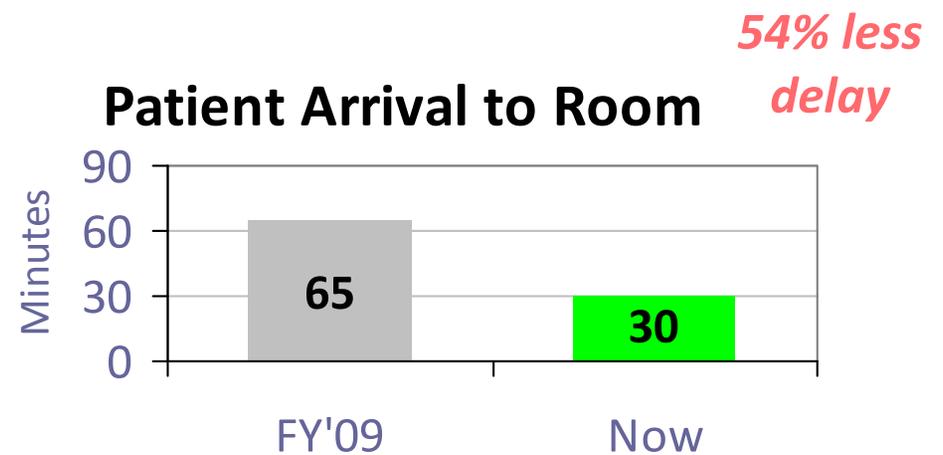
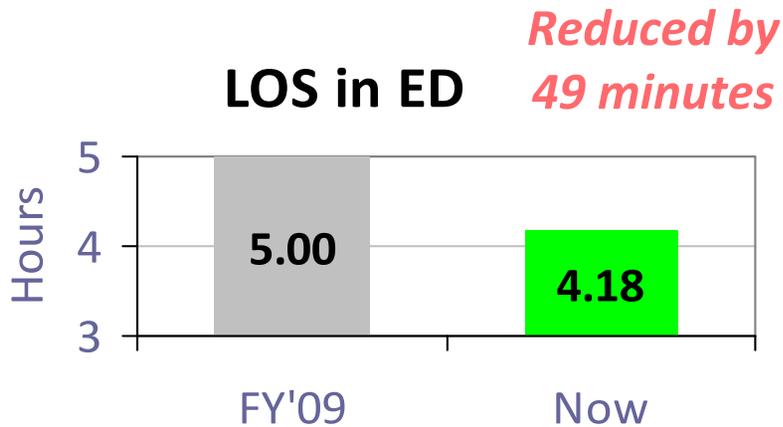
- Attending the weekly 1 hour meetings
- Communicating with peers and collecting feedback and concerns
- Continuous improvement: revisiting changes as necessary



# Improvements as of April 2011 (before Charlie pod)



# Improvements as of September 2011 (Charlie pod open)



# Challenges

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- Developing buy-in of large and diverse staff
  - Multidisciplinary
  - Range of experience levels
- Managing resistance
  - Change is difficult, and the familiar tends to be comfortable
- Staying the course
  - Big process changes will encounter multiple bumps in the road
  - Our doors never close while we make change
  - Standardizing expectations
- Maintaining our academic mission

# Lessons learned

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- Maintaining focus on the patient & family experience is key
- Crucial to have the support of hospital sponsors
- Front-line involvement from the beginning is extremely important
- Leadership team must be visible, accessible, and always in alignment
  - RN Director, Clinical Director, Administrative Director

# Patient response to the redesign

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**“No delays ... I didn’t have to wait at all from time I [checked in] until the time I was in the room ... it was less than 5 min. ER staff the best!!”**

*(Press Ganey, 2011)*