

ED/Throughput Best Practice Suggestions

This list includes feedback/recommendations received from hospitals. The intent is to organize them into broader interventions that could potentially be implemented more broadly in all hospitals. The specific interventions are ones that would be appropriate for some, possibly not all hospitals depending on patient populations. Highlighted interventions are the ones that staff recommend further for discussion/review. The other monitoring/measure suggestions include recommendations for possible outcome measures and compliance tracking; these may not be appropriate for this policy but could be beneficial to evaluate outside of this policy. Also included in the feedback received are comments on revenue at risk and other comments.

Broader Interventions

- **Implementation or Optimization of Bed Capacity Alert Process**

- Hospital has recognized increasing bed capacity issues that limit the ability to admit patients to inpatient beds from the ED, PACU, and or external transfers. An early alert notification system was developed in March 2024 that will be utilized 7 days per week triggered by specific hospital census or bed capacity values, ED boarder volume, or ED diversion. Alerts are sent to key executive and clinical leaders and a capacity call is initiated to identify any actions that can be taken to remove barriers to discharge, facilitate utilization of the discharge lounge, and identify PCT or RN for immediate discharge expediter role. Capacity calls are initiated every 2 hours until bed capacity limitations have been resolved.
- Code HOPE (Help our Patients in the ER)-in place for several years. An alert is triggered by specific hospital census or bed capacity values or ED boarder volume. A CODE HOPE alert is sent to all leadership, all staff, outpatient practices, and currently considering adding local skilled nursing and rehab facilities. While in Code HOPE status, mandatory leadership huddles (including CEO, CMO, CNO, all medical directors, etc.) occur at 10 am and 3pm. Huddles occur in the ED; non-essential meetings are canceled; elective cases and tests are evaluated for rescheduling depending on number of holds; and specific actions are triggered for the clinical and ancillary teams both inpatient and the ED.

- **Standardized Daily or Shift Huddles**

Using Huddle Boards, where goals and critical-to-safety leading indicators are tracked and trended. Include ED specific measures as well as real-time information. Hospital/unit to select other measures as appropriate for patient population.

- **Application of Lean and Continuous Improvement methodologies in the**

ED, including the routine use of tools to reduce wait times, eliminate waste, and improve

efficiency. For example, time-value analysis through process mapping, 5S, and Kaizen events, engaging staff in rapid improvement events to test new approaches for reducing wait times in real-time scenarios.

- **Care Management/Care Transition Interventions**

- Number of case management interventions inpatient—set targets with point allocations
- Case management staff available inpatient 24/7 or 7 days/week? —set target ranges with point allocations
- Case management availability in ED 7 days/week-set targets with point range allocation
- Utilization of ED discharge planners
- Utilization of Inpatient discharge planners + a measure of how many inpatient discharges were identified in the discharge planning portion of Epic for discharge 3 days in advance.
- Appropriate Social Supports in the ED
Frequent utilization of the ED by individuals in need of social services is common. While these multi-visit patients have an impact on overall utilization, their contribution to ED wait times is minimal. With appropriate social supports in the ED, the multi-visit patients can be screened and discharged rapidly, however it is important to note that the social supports are addressing an unmet need in the community and may indeed make the ED a more attractive destination for individuals who cannot access community-based resources. While the right thing to do by patient care, these resources may increase ED utilization. Examples include social work in the ED, peer recovery specialists, and other potential best practices where duration and amount would be established through HSCRC process and stakeholder engagement.

The above potential interventions would require further consideration and input from industry stakeholders to ensure the policy approach is thoughtful and truly measures outcomes over which hospitals have a degree of control.

- **Best practices related to Discharge by Noon efforts**

(e.g., daily discharge labs starting at 5am, reporting Discharge by Noon rates by unit)

- **System Focus on Appropriate Utilization and Best Practices**

- Convene ED leaders to develop system-wide policies and programs that optimize care delivery.
- ED throughput can be modestly improved using evidence based best practice guidelines. The hospital that made this recommendation embarked on an initiative to embed ED evidence-based care guidelines in the electronic medical record. To date they implemented 250 guidelines at the point of care, many system wide. Designed by an interdisciplinary team, the guidelines direct best practice in accordance with

current evidence, inform providers about appropriate use of tests, treatments and hospital admissions and include specific operational information to increase efficiency.

- **Implement/Optimize Interdisciplinary Rounds**

- Interdisciplinary team (as defined by each hospital but including core roles) meets daily to review patient progress and remove/escalate barrier to discharge

- **Measure and Communicate ED Admission Rate Transparency (set performance targets)**

- Provide the ED Providers with their ED admission rate and how they compare to their peers.

- **Track and Measure ED Clinical Pathway Compliance (set performance targets)**

- Decrease variability in admission rate of specific diagnoses using clinical templates. This will increase the use of ambulatory visits and decrease hospitalizations.

- **Track and Measure Operational Efficiency Measures (set performance targets)**

- Monitor and improve the TAT of vital ancillary tests that correlate with improved LOS. Ex. ECHO, MRI, Lab, but could be different for different facilities).

- **Implement/Optimize Observation Patient Management Process**

- Standardized workflow for these patients and prioritizing these ancillary tests will drive down LOS and increase throughput

- **Patient Flow Council/Performance Improvement Throughput Councils (multiple suggestions received, similar models)—points obtained at various levels; example outlined in the slide**

- Multi-disciplinary council of leaders, chaired by CMO or other Executive, meets every two weeks or more frequently as needed, to evaluate patient flow and track progress of patients as needed
- Inclusion of front-line staff on the Council
- Sharing of data and KPIs with front-line staff
- *Similar suggestion received describing a multi-disciplinary “Strike team” that performed similar reviews, but is less formalized*

Specific Interventions

- *Waiting Room RN and Support Tech*

- The waiting room RN initiative places a provider in the waiting room areas of the emergency department to create multiple touch points with patients seeking care and to support initiation of the screening and triage process. The waiting room RN also provides an opportunity for faster escalation of care in the event of patient deterioration and creates a communication channel for patients to improve patient satisfaction. In addition, the involvement of a support tech in the ED has allowed the ED RN team to focus on the care of their patients while operating at the highest level of their license. The support tech performs functions such as phlebotomy, EKG's, supports transport needs, and ensure appropriate stocking of necessary supplies.
- **Implement Subacute Placement Oversight**
 - Leadership monitors all potential sub-acute placements each morning; discharge planner follows up with any patients who don't have a referral by the afternoon
 - *This could be part of Case management bucket of measures listed above?*
- **Expediting Team**
 - An expediting RN and physician work closely with the hospitalists, consultants, nursing teams, and care management to address barriers for patient throughput
- **Rapid Medical Evaluation**
 - A rapid medical evaluation process with a dedicated physician and nurse in the ED to care for patients not requiring admission; the team also re-evaluates patients who are awaiting care.
- ***Real-time wait time tracking in the ED***
 - Communication (using screens) to keep patients and family members informed while waiting.
- ***Standardized ESI assignment protocols***
 - To ensure consistency and efficiency.
- ***Rapid Evaluation Units (or equivalent)***
 - To improve wait times for ESI 4 and 5 patients (low acuity), essentially monitoring and promoting fast-track utilization to create efficiencies.
- **A fully staffed 24/7 observation unit**
- **A staffed discharge lounge**
- **Deployment (and associated cost) of tools to increase provider efficiency**
(e.g., scribes, AI notes, voice dictation)

- **Enhanced Discharge Process**
 - Using electronic communication systems, link the ambulatory availability to both ED and inpatients so patients can either be discharged from the ED safely for rapid follow up or early from the medical floor
- **Sepsis Readmission Initiatives**
 - Discharge pathway for sepsis patients (standardized process and discharge with priority follow up with outpatient provider or at an ID outpatient clinic)
- **Comprehensive Care Centers for Chronic Conditions (i.e. CHF)**
 - High-risk post discharge clinic that sees patients at high risk for readmission
- **EMS Offload**
 - EMS Offload in the Emergency Department to improve EMS turnaround times

Monitoring/Measure Suggestions (more outcome and capacity/utilization focused)

- Length of Stay: recommend a hospital LOS measure that is focused on a patient population for which hospitals have a degree of control over the outcome. This measure could apply to patients who are discharged to home, or patients under certain disease processes. We would suggest a metric tied to Observed over Expected (O/E LOS) for an agreed upon hospitalized patient population. Improvement and attainment targets can be set.
- Consistent Monitoring by HSCRC Staff of Staffed and Licensed Beds: MHCC annual reporting of licensed beds is a good proxy for staffed beds on yearly basis, however some hospitals may reduce and flex up staff throughout the year. Greater transparency and monitoring of licensed, staffed and occupied beds are needed. Additionally global budgets should have greater alignment with licensed beds. Staff could consider a staffed beds measure as a best practice; This measure could include med/surg beds, intensive care unit beds, and potentially pediatric beds if applicable.
 - Related to bullets 1 and 2 above, a measure which monitors ED boarding hours would be the important leading indicator of improved hospital capacity. Reducing boarding is demonstrated in the ED literature to directly correlate with improved ED LOS and improved ED efficiency.
- Some measure that shows difficulty in discharge of inpatients such as number of denials to post-acute facilities (or perhaps certain categories of those denials).

Additional Hospital Comments

Revenue at Risk

As currently drafted, the plan for this policy is to tie the best practice measures to 1% of inpatient hospital revenue. This system urges HSCRC staff to reconsider this percentage. While hospitals do maintain some degree of control over ED LOS and can engage in additional initiatives to improve performance and patient experience, there are several factors entirely out of hospitals' control that may impact performance on these measures. Hospitals should not be penalized over measures where control is limited. The timeline for policy development is tight, and while gathering feedback from the industry in this expedited timeline is critical, this is a significant amount of revenue at risk for a measure developed in such a short time frame. It is necessary to craft these best practices and interventions while considering how to mitigate any harmful unintended consequences before implementing and potentially penalizing hospitals.

Other Comments

Capacity, Geographic Variation and Inpatient LOS Comments were also received. Individual hospital concerns will continue to be addressed in discussions with appropriate stakeholders. The ED Wait Time Reduction Commission will also evaluate these issues and make recommendations. We will discuss further during the meeting