MHA Long ED Wait Time Task Force

The Healthcare Council
July 27, 2023

Lisa Tenney, BSN, RN, CEN, CPHRM, FAEN
Government Affairs Chairperson
Maryland Emergency Nurses Association

Introduction

Lisa Tenney, BSN, RN, CEN, CPHRM, FAEN

Maryland Emergency Nurses Association

- Chair, Government Affairs Committee
- Chair, Education Committee, Mid-MD Chapter ENA

Holy Cross Hospital, Silver Spring, MD

Over 45 years Nursing Experience

- Adult and Adolescent Inpatient and ED Psychiatry
- Emergency Department
- Critical care and med-surg float
- Nurse Educator
- Nursing Leader in Psychiatry, ED, Staffing, Quality, Education
- Project Manager – Hospital Patient Care Model Redesign
- Co-lead, Institute for Healthcare Improvement Collaborative for Hospital and ED Throughput
- Risk Management/ Patient Safety Coordinator
- Patient Experience Coach/ Patient Relations Practitioner

Member, State EMS Advisory Council (SEMSAC)

Hospital and ED Throughput Lens

- ✓ Maryland ENA's representative for 1000+ ED nurses
- ✓ National ENA leader with the Academy of Emergency Nurses
- ✓ Acute care Hospital risk manager, patient, and patient safety advocate
- ✓ As an experienced hospital and ED throughput leader

Hospital Throughput Lens

Hospital crowding is primarily driven by obstructions to discharge

- ✓ Lack of Rehab and SNF beds for Baby Boomers
- ✓ Lack of STAFFED Rehab or SNF beds
- ✓ Difficulty arranging a safe discharge for homeless patients
- ✓ Difficulty arranging timely Home Care or Infusion Services
- ✓ Lack of behavioral health inpatient beds
    - Adolescent and residential treatment facilities
    - Medical-Psych patient (dialysis, pregnant, cognitively impaired, neuro-psych, autistic, geriatric)
    - Inpatient and outpatient substance abuse/addiction services
- ✓ Lack of timely behavioral health follow-up resources
- ✓ Uncooperative patients (refuse to leave)
- ✓ Unwilling or unable families to care for patients; or NO family (guardianships)
- ✓ Lack of social service resources (foster parents, group homes, etc.)

ED Throughput Lens

ED has patients who could be cared for in other settings

- Patients with violent/criminal behaviors brought in by police
- Previously discharged patients who were unable to see a doc, get meds, get tests, home care
- PMDs send patients to the ED, rather than office, for an expedited workup>

ED crowding is primarily driven by factors outside of the ED

- Increased Hospital lengths-of-stays → Admitted ED patients board in ED stretchers
- Most ED patients are cared for in the waiting room or a hallway →
- Most ED clinical time is split between caring for boarding inpatients and new ED patients →
- EDs must: See all patients (EMTALA) and take care of sickest patients first

  (ESI levels I, II, III, IV, V) →
- This has led to a filled waiting room of lower acuity (III, IV, V) patients →
- Waiting is painful; tempers flare, LWBS, threatening and violent behavior, condition worsens →
- Have put bandaids and work-arounds in place

ED Throughput has 3 Phases

I. Expediting time to MD

Door-to-doc
(ED Internal)

II. Expediting Diagnosis

Doc-to-Diagnosis
(Collaborative)

III. Expediting Discharges, Transfers, Admissions

Decision-to-Disposition
(Collaborative)

Source: Advisory Board Company

Most ED Throughput delays occur in Phase III

Each Throughput Phase Has Specific Work

Source: Advisory Board Company

I. Expediting time to MD

Door-to-Doc

Four Entry Sources
- Door-walk in
- EMS, police
- Internal transfer
- External transfer

Quick Look/Sort RN - assign ESI

Route to appropriate ED bed

Patient Registration

If no bed, Waiting Room Triage

II. Expediting Diagnosis

Doc-to-Diagnosis

Exam by doc
Life-saving measures ESI I, II
Tests and treatments
- Labs
- X-rays
- CTs, Sono, Nuclear Medicine
- EKG, Echo
- IV line and fluids
- Breathing treatments
- Medications
- Wounds, dressings

Consults with specialists
Make Diagnosis

Consult with PMD or admitting physician on plan of care

III. Expediting Discharges, Transfers, Admissions

Decision-to-Disposition

Admit
- OR
- Cardiac Cath Lab
- ICU
- Tele, Med-Surg, Peds, L&D
- Behavior Health

Discharge
- Home
- Home with social services
- SNF via private ambulance

Transfer
- Higher level of care
- Specialty Hospital
- Kaiser HMO Hospital
- C4 –C4Peds

Barriers to Each Throughput Phase

Source: Advisory Board Company

I. Expediting time to MD

Door-to-doc

Not enough beds
(Demand higher than capacity)

Not enough Specialty Beds
(Peds, Critical Care, Minor Care, Geriatric, Psychiatric, etc.)

Not enough staffed ED beds
(Decreased staff and decreased specialty trained staff)

Patient Registration staff
(staffing shortages, mechanical difficulties, supply chain issues)

II. Expediting Diagnosis

Doc-to-Diagnosis

Delayed testing and treatments or receiving results from lab, radiology, respiratory, psychiatry, interventional radiology, dialysis, pharmacy, etc.

Delays in support services
- Supply chain
- Mechanical difficulties
- Staffing shortages

Patient delays
- Lack of consent
- Unable to find family, surrogate, guardian
- Special needs)

III. Expediting Discharges, Transfers, Admissions

Decision-to-Disposition

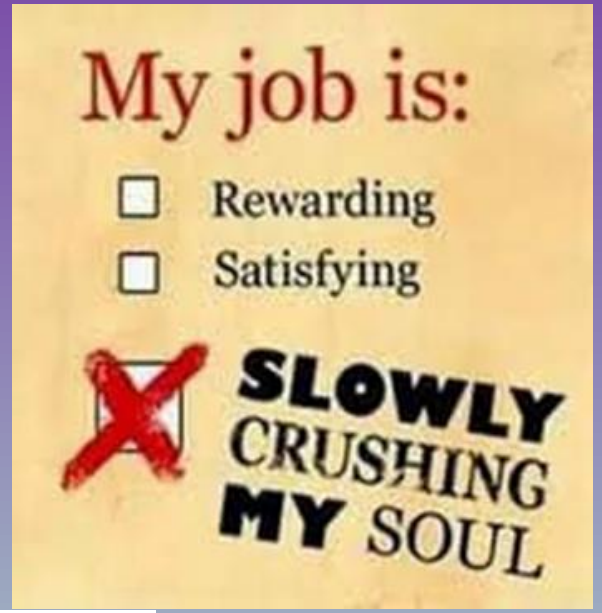
Admit
- **No inpatient beds**
- Rooms blocked (CBA)
- No staffed inpatient beds
- Housekeeper Shortages
- Specialty team not available
- **No Behavior Health beds**

Discharge
- **Homeless**
- No one at home to give care or come get Pharmacy delays
- **Home Care unable to get there**
- Needs social services
- SNF can't or won't take back
- Private Ambulance delays
- **No outpatient Psych Resources**

Transfer
- Higher level of care bed not available
- Specialty Hospital bed not available
- **Kaiser HMO Hospital bed not available**

The Voices of Maryland's Emergency Nurses

- Caring for inpatients and ED patients simultaneously
- Long term psychiatric boarders!
- Short staffing in every department
- Staffing mix (experienced vs. novice or temps)
- Hospital financial crisis, lay-offs, corporate changes
- Drug and medical supply price increases and shortages
- Violent patients mixed with sick geriatric and pediatric ED patients
- Increased threats and physical workplace violence
- Patients and families are very unhappy



Opportunities

1. BEDS = Capacity to meet Demands

- Acute Care
- SNFs, Rehab
- Acute Behavioral Health (Inpatient, Outpatient, Pediatric, Adolescent, med-psych, neuro-psych, special needs)
- Adolescent Behavioral Health Residential treatment facilities
- Addiction/Substance Abuse facilities

2. MONEY = Increased reimbursement and grant $$$ needed to support staff and facilities

- More ED docs
- More RNs, all specialties
- More radiology technologists, etc.
- Like 2023's HB 418 /SB 283 Mental Health - Workforce Development - Fund Established

3. Create Law Enforcement Medical Forensic Units for individuals with violent/criminal behaviors

Define Success of the Throughput Task Force

ED throughput measure = “Door- to- Decision” time (not door-to-doc)

- Use Carrot, not stick
- Provide bonus to hospital for decreasing Door-to-Decision without increasing 30-day readmissions

ED throughput measure = the decrease in the number of ED visits primarily attributable to criminal activity/behavior, homelessness, and other non-medical/social issues

Hospital throughput measures = IHI’s measures

- ED = Decision-to-Disposition (depart) time to inpatient medium transfer time
- PACU = Time met disposition criteria to inpatient medium transfer time
- ICU = Time of transfer order to Medium transfer time
- Med-Surg = Time of transfer order to SNF-to medium transfer time

Source: Institute for Healthcare Improvement: Improving Flow Through Acute Care Settings