Rapidly and Reliably Improve the Patient Experience in Your Busy Immediate and Urgent Care Centers

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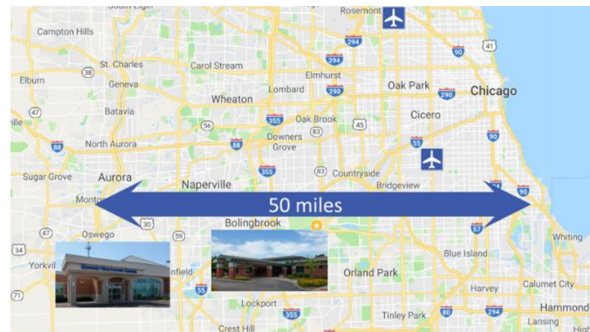
To follow are the notes from a webinar that was conducted on May 2, 2018. You can watch the recorded webinar at http://smart-er.net/rapidly-and-reliably-improve-the-patient-experience-in-your-immediate-care-centers



Edward Elmhurst Health (EEH) is a 3-hospital healthcare system in the western Chicago suburbs that operates 3 emergency departments (EDs), 7 immediate care centers (ICs) and 14 walk-in clinics. All these acute, unscheduled care sites are currently governed by a single administrative service line.

In 2014, due to poor performance, oversight of the EEH-owned ICs was transferred to the ED leadership team. Prior, the sites fell under corporate health as they provided occupation health services. Two ICs (in Bolingbrook and Oswego, IL) fell under the Edward Hospital umbrella had a combined annual volume of 40, 000 and had more comprehensive than most ICs with point of care labs, plain radiology, CT and ultrasound. Provider staffing included family medicine and emergency physicians as well as physician assistants and nurse practitioners.

This presentation is frontloaded with information on change management strategies. This is because it is common for us to have great ideas on what would make a process better, but we are not all experts on change. Time is wasted if good recommendations cannot be implemented because the leaders are ineffective with change management. It is human nature for staff to resist change unless there is a compelling reason to do so (as perceived by the person that needs to change their behavior). Command and control an unhealthy way to evoke change. True leaders are visionaries that serve the staff that they oversee. They shift behavior in positive directions through education, encouragement and motivation.

We all know that change begins with a “burning platform.”

At EEH, in 2014, the C-suite expressed concern that the ICs had poor patient satisfaction (e.g., 45 min door-to-provider and Press Ganey percentile ranking in the bottom half) and needed to support further growth of the system. The Occupational Health department had been reluctantly been overseeing the new ICs for the decade prior.

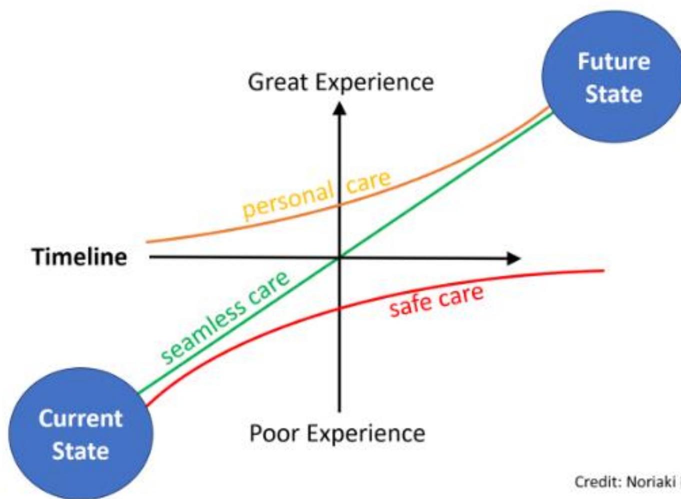
The ED had exemplary satisfaction scores (top decile every quarter) and so were asked to take over the ICs. The CEO wanted rapid results with a neutral budget. This was quite a tall challenge.

First, we (the ED leaders) needed to be sure that our own beliefs supported the project. It needed to adopt as *our* "burning platform." Once we truly believed that oversight of all sites for acute unscheduled care made sense to us and for the system and, in particular, was in the best interest of our the patients, we became committed.

The term "burning platform" was coined 1988 after there was an explosion and fire on Piper Alpha, offshore oil drilling platform in the North Sea off the Scotland coast that killed 188 died. The 63 survivors jumped 15 stories to the water. They needed to make a fast decision and chose *probable* death over *certain* death.

Today's reality is that there is growing competition in the IC space. Major players and individual owners (plus a growing number of walk-in clinics and telemedicine practices).

Loyalty in IC results in stickiness of a relatively younger, healthier population. Because of our improvements, we have seen ongoing IC growth despite more market competition.

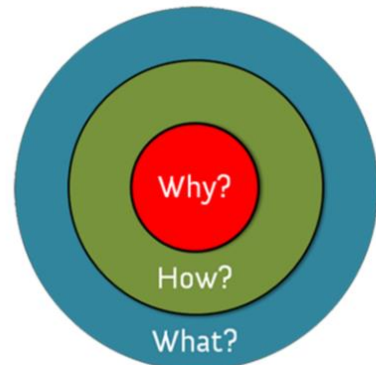


The EEH vision is to provide *safe, seamless and personal care* to our patient. *Safe* means quality, *seamless* means cost and time-efficiency and *personal* results in both patient and staff experience. These are the essential components of loyalty.

Noriaki Kano, a quality management professor from Tokyo, developed a satisfaction model demonstrates that impact of each element of the EEH vision.

Moving from a current state to a future state of a better experience requires, first and foremost, *safe* care. You will never achieve high satisfaction with the wrong diagnosis or treatment plan (no matter how fast you saw the patient or how engaging you were). *Seamless* care (e.g., time-to provider) linearly increases satisfaction. *Personal* care represents the "wow" attributes that fortify loyalty. This might occur if a patient left feeling like they were treated as a family friend might be.

Simon Senek uses the Golden Circle to explain why great leaders work from the "inside out" and relay the 'why' we should do something rather than the 'what' we are planning to do and 'how' we might accomplish the change. They communication the purpose of the change and connect it to the individual's and the organization's shared values. This creates strong buy-in and a sense of urgency. Put more simply, we should lead with our heart and not with our head.



Check out Simon Senek's TED talk on the topic at http://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action.html.

QUEST

Idea Benefit = $QUEST_{future} - QUEST_{current}$

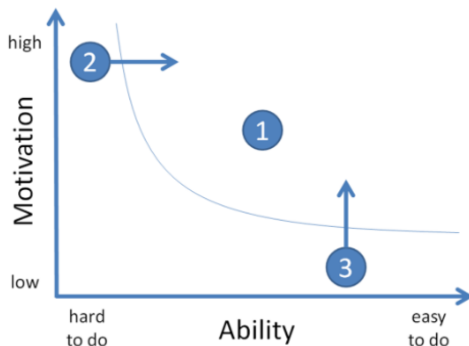
Idea Cost = any obstacle linked to implementation

Idea Value = *Idea Benefit* / *Idea Cost*

Leaders get flooded by problems. To determine the solutions with the most merit, you can use the QUEST framework. QUEST stands for quality, utilization, efficiency, satisfaction and teamwork.

The benefit of a new idea can be illustrated by the equation, $QUEST_{future}$ - $QUEST_{current}$. This is the margin between the future and current state and broken down by each component. The true value of a new idea incorporates the cost, which can be time, money or distraction from more important endeavors. Read the full QUEST article at [https://www.medscape.com/viewarticle/893.](https://www.medscape.com/viewarticle/893) (Medscape requires a free subscription.)

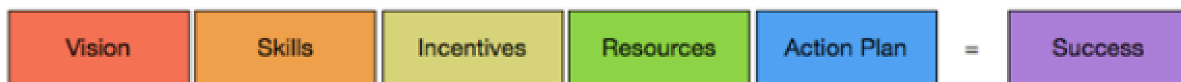
The "Law of Diffusion of Innovation" by Everett Rogers, a communication theorist and sociologist, describes the source of traction for new ideas. Innovators create change and early adopters readily accept change. This group together is 16% and are budding leaders and enthusiastic staff members and the ones that can and must influence the early majority. Once about half of this middle group buys in, a *tipping point* is reached and momentum carries the last two-thirds since no one wants to be labeled as a laggard. So, at the onset of a change plan, there is no reason to worry about the late majority.



Change becomes much easier when there is both motivation and ability present in the majority. BJ Fogg, a behavioral psychologist that founded the Stanford Behavior Design Lab, suggest that these two factors are essential to have in place to persuade others to evolve from what they have become accustomed to do.

By making change simpler through skill building, staff become confident. With compelling (non-monetary) incentives, motivation is sparked. So, consider who is motivated and needs ability (or vice versa) when you are hoping to change behavior.

The Knoster model for managing complex change demonstrates the five requirements to assure the successful implementation of a new program. When just one item is missing, change is jeopardized. For instance, *confusion* occurs when there is no clear vision, *anxiety* occurs when skills are inadequate, *resistance* occurs without incentives, *frustration* occurs when resources are insufficient, and *false starts* occur without an action plan.



Bringing stakeholders together to plan and execute change is critical. So, work across boundaries, encourage staff to break out of their silos, and refuse to tolerate unhealthy internal "competition."

For the immediate care center project, key stakeholders were nurse and physician leaders, all categories of frontline staff and ancillary department representatives like radiology techs and patient access staff.

Frequent meetings were conducted to define the current state and the ideal future state. Lean/6-sigma principles such as DMAIC (Define, Measure, Analyze, Improve, Control) were followed. Improvement ideas were attached to metrics that were attainable, straightforward and relevant.

Staffing optimization is a balancing act. We drilled down on patient arrival patterns and revised provider schedules to match the patient influx. We blended technicians and advanced practice providers into the mix the originally consisted of physicians and nurses.

We were mindful to balance the cost of staffing with the cost of waiting, which threatens loyalty. Charge nurses took ownership of holding staff accountable for patient throughput.

Occupational Health moved to a designated space with separate staff. We severely reduced the number of PRN providers as they were less committed to behavior modification.

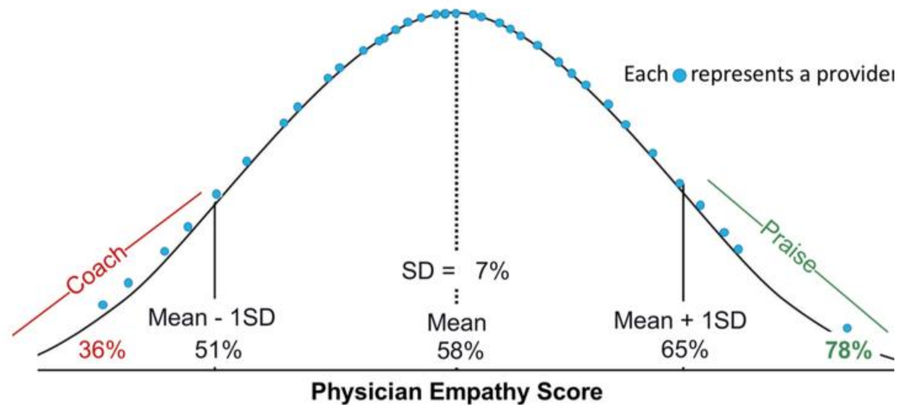
There were several process changes related to shifting from serial to parallel processing. Initially, one queue formed for all arrivals whether for immediate care, occupational health, and outpatient testing. Instead, we separated out the immediate care arrivals. More importantly, whenever a room was unoccupied, arrivals were assigned and moved to it after a 15-second EMR "quick arrival" (name and chief complaint entry). Registrars then performed the full registration at the bedside using rolling computers and scanners.

We swapped the outpatient version of our Epic EMR for the ED version, called ASAP. This allowed tracker board to be set up so that all staff saw the big picture and not just the current patients they were assigned. Tracker board icons provide quick reference to patient status/orders.

Bed	F	S	Age	CC	A	TT	TIR	RN	MD/PA	POCT	Rad Stat	D	Reg
01		M	36	Lower Extremity Injury (m...	4	01:13	01:04	Nikki N	Syed, U		✓[1/1]		✓
02		F	3	Redness	4	01:04	00:54	Anne V	See, A				✓
02		F	28	Irritation	4	01:04	00:54	Anne V	See, A				✓
03													
04		M	74	Rash Skin Problem (integ...	4	00:16	00:14	Anne V	Syed, U				✓
05													
06		F	64	Lightheadedness; Nause...	4	01:43	01:41	Nikki N	Johnston	! [1/2]			✓
07													
08		F	57	Foot Pain	4	00:33	00:31	Anne V	See, A				✓
09													
10													
11		F	65	Sinus Problem; Cough/U...	4	00:33	00:31	Tara B	Johnston				✓
12													
14		F	16	Upper Extremity Injury (m...	4	01:25	01:19	Nikki N	See, A		✓[1/1]		✓
WR													

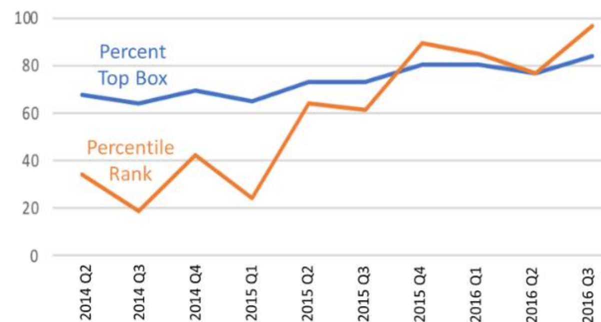
Nurse charting was streamlined by incorporating templates and this greatly decreasing the need for time consuming, narrative documentation. We began using the emergency severity index to help prioritize cases and, on the backend, to calculate workload units per patient and this allowed a more refined way to assess and reward provider productivity.

The degree of "personal care" delivered by the providers was measured using results from a next-day survey question that assessed the patient's perception of provider loyalty.



Because we achieved statistically-valid provider data monthly, we could track provider performance. When we identified low performers, we initiated a coaching program. This began with the medical director sharing observations and advice. On occasion, low performance persisted and then sessions with external coaches were arranged accelerating improvement.

When providers doing well with patient-perceived empathy, drifted into the low performer group for two consecutive months, the medical director may uncover a personal issue (e.g., burnout, depression, family struggles, etc.). Early identification of these types of issues allows for interventions that help keep job security and provider reputation intact.

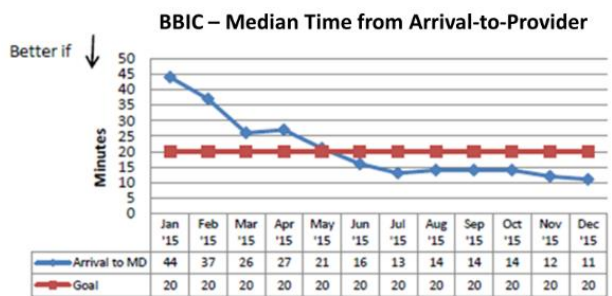


Press Ganey top box scores moved up from 65% to 85%, translating into a percentile rank increase from under the 50th percentile in 2014 to over the 90th percentile 2016. This improvement has never dropped down and was lauded by system administration.

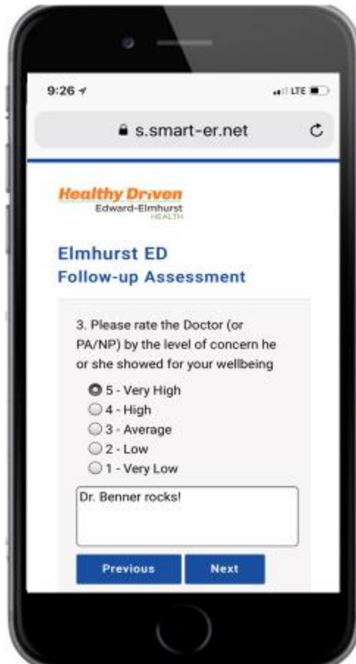
Close attention was the patient comments that constantly came in from the SmartContact survey, which gave us further ideas on what perceive as pain points so continuous improvement persisted.

The process changes we made resulted in the door-to-provider time decreasing from 44 minutes in 2014 to 11 minutes in 2016. Patients appreciate being immediately roomed and that there is a flurry of activity since they can be seen by any staff, in any order (nurse, provider, registrar).

Creating a low door-to-provider time is mostly a registrar and nurse accomplishment and should not be misattributed to providers when giving praise.



The 5-question SmartContact e-survey, which is delivered the day after the visit to check patient wellbeing and experience. Providers differentiated by the request, "Rate the provider by the level of concern shown for your wellbeing." The top box choice, "Very High" level of concern, is compares individual providers and nurses.

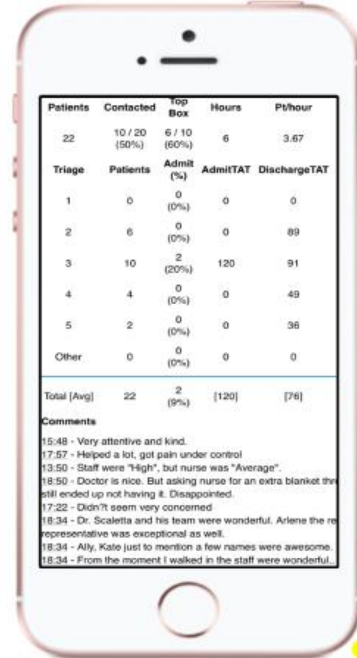


11/2014

Patients seen	Contacted	Top Box
323	36 (11.1%)	55.6%
197	25 (12.7%)	80.0%
185	18 (9.7%)	61.1%
149	9 (6.0%)	44.4%
146	16 (11.0%)	43.8%

11/2017

Patients seen	Contacted	Top Box
409	126 (30.8%)	70.6%
395	140 (35.4%)	55.7%
362	107 (29.6%)	69.2%
336	127 (37.8%)	71.7%
301	102 (33.9%)	71.6%



Patients	Contacted	Top Box	Hours	Pt/hour
22	10 / 20 (50%)	6 / 10 (60%)	6	3.67

Triage	Patients	Admit (%)	AdmitTAT	DischargeTAT
1	0	0 (0%)	0	0
2	6	0 (0%)	0	89
3	10	2 (20%)	120	91
4	4	0 (0%)	0	49
5	2	0 (0%)	0	36
Other	0	0 (0%)	0	0
Total [Avg]	22	2 (9%)	[120]	[76]

Comments

15:48 - Very attentive and kind.
17:57 - Helped a lot, got pain under control
13:50 - Staff were "High", but nurse was "Average".
18:50 - Doctor is nice. But asking nurse for an extra blanket thr
still ended up not having it. Disappointed.
17:22 - Didn?t seem very concerned
18:34 - Dr. Scaletta and his team were wonderful. Arlene the re
representative was exceptional as well.
18:34 - Ally, Kate just to mention a few names were awesome.
18:34 - From the moment I walked in the staff were wonderful..

In the monthly provider reports, you can see 2014 compared with 2017. Currently, all providers consistently achieve above 50% top box except for one that has been amenable to outside coaching. Since there are less part-timers, there are more patients per provider. Increased response rate reflects better acquisition of email, cell number by the registrars.

Providers receive a shift report to their personal email 2-days after each shift so that they can reflect on their productivity and patient feedback scores and comments.

If you have any questions or comments about this presentation, please contact us!

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