Clinical Quality and Service Excellence

As our grandmothers used to say, “Beauty is in the eyes of the beholder.” So is quality. Is it getting a blood culture before antibiotics, keeping patients informed, greeting private attending on arrival, admitting an increasing % of the ED patients…? The presenter will describe how quality and service excellence intersect, by presenting the different perspectives and ways to address them all.

Objectives:

- Define quality from the various perspectives (Emerg. Phys, RN, Patient, Admin, PCP, etc.).
- Describe the ways that we do (don’t) meet quality expectations.
- Describe the A-Team, B-Team behavior and its influence on quality.
- Explain the value of goal setting, measurement and feedback.
- List tools to improve quality and service excellence.

5/22/14
9:45 AM - 11:15 AM
Course Number: TH-18
Trinity Ballroom 4-8

(*)Jay Kaplan, MD, FACEP

Dr. Kaplan is Director of Service and Operational Excellence for CEP America Emergency Physician Partners and Medical Director of the Studer Group. He is a current member of the American College of Emergency Physicians Board of Directors. A graduate of Harvard College and Harvard Medical School, Dr. Kaplan won teaching awards in 1996 and 1999 and in October 2003 was named the American College of Emergency Physicians’ Outstanding Speaker of the Year. In 2007, Studer Group honored him with the prestigious Physician Fire Starter Award. In January 2011, he was awarded the Grace Humanitarian Award by the Thomas Jefferson University Hospital Department of Emergency Medicine.

Dr. Kaplan served as Chairman of the Department of Emergency Medicine (1985-2001) and as a Medical Staff Officer including Chief of Staff (1992-2001) at Saint Barnabas Medical Center in Livingston, NJ. As Chairman of Emergency Services for his health system (1998-2001), he led his system’s emergency departments to the 98th percentile in patient satisfaction and his own emergency department was in the > 90th percentile for 6 years in a row (1996-2001).

As a national speaker and facilitator, Dr. Kaplan presents to and coaches hospital leadership teams, emergency departments, medical groups and physicians to the highest levels of clinical quality and service excellence. He engages and interacts with his audience and makes listening fun. His approach is tactical and directed toward implementation not just ideas, toward results not consults.

Dr. Kaplan continues to practice clinically because he loves the clinical practice of medicine, and caring for patients helps him remain close to the patients’, the hospital staff’s, and the physicians’ current experience. He lives with his wife and family in the San Francisco Bay area approximately 20 minutes north of the Golden Gate Bridge.

(*+)No significant financial relationships to disclose
ED Efficiency - Clinical Quality and Service Excellence

Jay Kaplan, MD, FACEP
Member, ACEP Board of Directors
Director Service & Operational Excellence, CEP America

From The Mayo Clinic

“The future viability of our organization will be dependent on our ability to deliver Service Excellence.”

“And importantly . . . A Commitment to Excellence will not manifest without the leadership, support and example set by physicians.”
From The Joint Commission

“Leadership has been identified as the most important ingredient in transformational improvement.”

From Joint Commission Resources presentation; Executive quality improvement survey results.
Journal of Patient Safety. 2 March 2006

From Thomas Edison

“When did you start seeing these imaginary people?”
Caveat #1:
What Brought Us to this Dance . . .

Ain’t Going to Get Us to the
Next One . . . .

Caveat #2 –
The Best Definition of Madness is

To keep doing things
the same way
and expect different
results . . .
Caveat #3
How Most of Us Approach Change

Caveat #4: To Get “Quality” Anything

- Systems
  - Process
  - Outcomes

- People
  - Staff
  - Patients
  - Physicians
Which Means . . .

Efficient Care/Flow
Staff Engagement
Office
Patient/Family Engagement
ED
Alignment of Behaviors
Inpatient
Transitions of Care
SNF

Communication gaps in nursing home transfers to the ED: impact on turnaround time, disposition, and diagnostic testing.

Nelson D, Washton D, Jeanmonod R.
Am J Emerg Med. 2013 Feb 1

- NH paperwork contained adequate HPI 35%
- Patients could provide their own HPI 28%
- Adequate HPI could not be obtained 32%
- No “statistically significant” difference (100 pts) in
  - TAT (146 vs 173 minutes, P = .22),
  - Admissions (60% vs 66%, P = .66)
  - Diagnostic testing (P = .89-1.0)
Caveat #5: It’s About The Team

While we give care seemingly individually,

- The Patient and Family Experience is dependent upon the coordinated actions of all members of the team . . .
- From the moment they walk in, to the moment they walk out or on . . .
- Success is never achieved alone.
- If it’s not always . . . It’s not great . . .

Caveat #6: Unhappy Doctors Don’t Make for Happy Patients

If we can’t give our day a “5”, it’s going to be awfully hard for our patients to give their experience with us and our day a “5” . . .
And no one is going to create that “10” for us unless we participate in the process.
What Do Emergency Physicians Want?

• Quality Care for Our Patients
• Efficiency of Our Practice
• Responsiveness to Our Issues
• Appreciation for What We Do
• Balanced Life – “Work to Live”
• Good Income

CEO’s Want . . .

• As Many Patients As Possible (especially high profit-margin cases)
• High Patient Satisfaction
• Efficient Throughput
• No Diversion/No LWOBS
• No Patient Complaints
• No Medical Staff Complaints
• No Premium Labor Usage
CEO’s Will Say . . .

- Here are my expectations.
- Get it done.

Problems:
- They don’t know how you can get it done.
- In most situations you are in charge of the emergency physicians but not the rest of the department.
- You have all of the responsibility but not all of the authority (you truly need).

The Roles of the Leader

- Define the Vision and Get Everyone on Board (Leader)
- Help Create a Great Practice Environment - Fix the Systems (Manager)
- Engage Your Staff and Providers - Create The Team (Team Player)
- Ensure Consistent Clinical Quality and Compassion (Healer)
The Key Upfront Questions

- Engagement – Does everybody understand why?
- Alignment – Is everyone on board?
- Action – What do we have to do?
- Accountability – Are we getting the outcomes?
  - If Yes → Recognize & reward
  - If No → Is it the skill? → Leadership training
    → Is it the will? → Time to get off the bus

The Burning Platform

Making All of What You Hear About “Quality” Personal –

Is Teamwork Important to Quality and Patient Safety?
Is Communication Important to Quality and Patient Safety?
Is Communication Important to Teamwork?
What is Quality?

Some Would Say . . .

- Clinical Quality is the real deal, the “hard stuff.”
- Service Excellence is the fluff stuff.

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The Cost of Satisfaction

A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Joshua J. Fenton, MD, MPH, Anthony F. Jerant, MD, Klea D. Berahin, MD, MPH, Peter Franks, MD

- Patient Satisfaction in year 0 (2000)
- Cost, ED & Hospital Admissions in year 1 (2001)
- Mortality in years 1-6 (2001-2006)
- Study Design poor/Conclusions invalid

Expenditures, 9.1% (95% CI, 2.3%-18.4%) greater prescription drug expenditures, and higher mortality (adjusted hazard ratio, 1.06; 95% CI, 1.03-1.13).

Conclusion: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

Arch Intern Med. Published online February 13, 2012.
Patient experience is positively associated with clinical effectiveness and patient safety. Associations appear consistent across a range of disease areas, study designs, settings, population groups and outcome measures:

- Positive associations: 429 studies
- No association: 127 studies
- Negative association: 1 study

Communication = Compliance = Quality

Physician communication correlates STRONGLY with adherence rates by patients in acute and chronic disease. There are now over 100 observational and 20+ experimental studies published demonstrating the correlation of communication (patient satisfaction) with compliance. Compliance with treatment regimens has significant influence on quality measures in chronic disease and outcomes.

*Medical Care*: August 2009 - Volume 47 - Issue 8 - pp 826
Does the Patient Experience Affect Quality?

which means . . .

just making the right diagnosis and
giving the right medicine, doing the
right procedure with technical skill . . .
is not enough.

30% of respondents had poor adherence to their cardio-metabolic medication regimens

After adjusting for potential confounders, the prevalence of poor refill adherence increased by 0.9% (95% CI, 0.2%-1.7%) (P = .01) for each 10-point decrease in CAHPS score.

Archives Internal Medicine 12/31/12
Risk Management

Strategic Risk Management: Reducing Malpractice Claims Through More Effective Patient–Doctor Communication

Bernard B. Virshup, MD, Andrew A. Oppenberg, MPH, and Marlene M. Coleman, MD

Case Study Editor’s Note: This paper is presented because is so well makes the case that projecting the demeanor of a caring person does not diminish our professional image. One is not the antithesis of the other. Being human is as much the embodiment of medicine/healthcare as is science and technical expertise; and certainly as necessary and prudent. The author(s) have posted a theory with expedient practical implications, something on which to hang one’s hat. The concept of patient-doctor relationship has more substance when related to risk management. More than “be nice” it illustrates how judicious is it to let patients know that we really do care about them and their overall well being; necessarily, these few interventions via compassionate care of our patient/quality decision, which are subliminal but compelling practitioners to be cognizant of the holistic interconnectedness, interaction, interrelation, and interdependence of a myriad of aspects and components that impact the reality and perception of what constitutes quality medical practice/healthcare. The focus of this article is the impact of the patient-physician relationship on malpractice litigation—a risk management issue. What is the quality of your patient relationships with you? We urge the reader to use this offering as a tool for self-evaluation or as a personal case study, if you will.
Beverly Carpenter-Mason, PhD
Case Study Editor

Relationship between patient satisfaction, complaints and lawsuits

- Each one point decrement in patient satisfaction scores is associated with a –
  - 6% increase in complaints (RR 1.06, 95% CI 1.03 – 1.08; p<.0001)
  - 5% increase in risk management episodes (RR 1.05, 95% CI 1.01 – 1.09; p< .008)
  - Lower performing physicians were at greater risks for lawsuits (RR = 2.10; p 95% CI 1.13 – 3.90; p< .019)
  - 75% of complaints were related to communication issues

Hourly Rounding - Call Light Study
(American Journal Nursing Sept 2006)

- **Operational Efficiency**: Call lights reduced 37.8%
- **Patient Satisfaction**:
  - Increased avg. 12 pts (78.8 -> 90.8) n=10
  - % Excellent ratings increased 41.8% (38.2% -> 81.0%) n=2
- **Clinical Quality**: Falls reduced 50% (average cost of fall $19,440-$22,000)

One year after study, 85% of units still doing the practice, 92% had spread practice to other units

Hourly Rounding (ED)

- **Operational Efficiency**: Call lights reduced 34.7%
- **Operational Efficiency**: Patients/Families approaching the nursing station reduced 39.5%
- **Finance**: LWOBS reduced 23.4%, LAMA 22.6%
- **Clinical Quality**: Falls reduced 58.8%
- **Patient Satisfaction**: Increased 20%ile in already high-performing ED’s
Does Staff Turnover Affect Quality?

Relationship Between Employee Turnover and Patient Outcomes

- Low: Organizations with turnover from 4% to 12%
- Medium: Organizations with turnover from 12% to 21%
- High: Organizations with turnover from 22% to 46%

Blue Bar: Mortality Index = Clinical Quality
Yellow Bar: LOS = Operational Efficiency
Y-axis: Employee Turnover = Service Excellence

- 28% greater mortality
- 24% longer stay

Quality in Our Patients’ Eyes

Patients’ Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care

- John T. Chiang, MD, MPH; Ron D. Hays, PhD; Paul G. Shekelle, MD, PhD; Catherine H. MacKenzie, MD, PhD; David M. Delbanco, MD; David D. Cauley, MD; Carol L. Math, RN, MPH; Carolyn J. Huang, MPH; John Adams, PhD; Ross T. Young, MD; and Nial B. Whelan, MD, MPH

Background: Patient global ratings of care are commonly used to assess health care. However, the extent to which these assessments of care are related to the technical quality of care received is not well understood.

Objective: To investigate the relationship between patient-reported global ratings of health care and the quality of provider communication and technical quality of care.

Design: Observational cohort study.

Setting: 2 managed care organizations.

Patients: Vulnerable older patients identified by brief interviews of a random sample of community-dwelling adults 65 years of age or older who received care in 2 managed care organizations during a 15-month period.

Measurements: Survey questions from the second stage of the Consumer Assessment of Healthcare Providers and Systems programme were used to determine patients’ global rating of health care and provider communication. A set of 238 quality indicators, defined by the Assessing Care of Vulnerable Elders project, were used to measure technical quality of care given for 22 clinical conditions. 207 quality indicators were evaluated by using data from chart abstraction or patient interview.

Results: Data on the global rating item, communication scale, and technical quality of care scores were available for 236 vulnerable older patients. A multiple logistic regression model that included patient and clinical factors, better communication was associated with higher global ratings of health care. Technical quality of care was not significantly associated with the global rating of care.
Quality in the Government’s Eyes - The Transparent Environment

Patient Satisfaction Measurement On-Line: HCAHPS

During your hospital stay, how often did doctors/nurses:

- treat you with courtesy and respect?
- listen carefully to you?
- explain things in a way you could understand?

Never/Sometimes/Usually/Always
## Pay for Performance For Hospitals Is Here . . .

**Value-Based Purchasing (VBP)**

- A specified percentage of hospital payment is conditional on performance
  - Reimbursement FY 2013: 1% withhold, payback based on performance - 70% clinical quality/30% patient experience
  - Will need to either be at 50th percentile or improve from previous score to earn points for that dimension

**It only gets more . . .**

- Reimbursement FY 2014 – 45% clinical quality/30% patient experience/25% outcomes
- Withhold increases 0.25% per year

## Pay for Performance for Physicians Coming Soon . . .

- **PQRS = Physician Quality Reporting System**
- Reporting of Quality metrics has been voluntary and rewarded with additional $
- FY 2015: Mandatory reporting of Quality metrics ($ penalty of 2.5-3% reimbursement if data not reported)
- CGCAHPS is the patient experience component for outpatient/office practice; ED CAHPS is the patient experience component for the ED (coming by 2014)
- Next Step: A specified percentage of physician payment will be conditional on performance (50% quality/50% cost)
The Old Paradigm

Care = Income

The New Paradigm

Exceptional Clinical Quality & = $$$
Extraordinary Patient Experience
Simple Truth #1: We Live in a Service Economy

Our entire staff is committed to your complete satisfaction and empowered to deliver personalized service to take care of your needs.

Key Words for Us

▼ **Satisfy**
  ▼ to please, to be adequate to an end in view, to meet an obligation

▼ **Astonish**
  ▼ to strike with sudden and usually great wonder or surprise

▼ **Memorable**
  ▼ worth remembering
Every Patient  
Every Time

“I am careful to make eye contact with every patient so that they know I am giving them my attention.”

“I put a blanket over and under every elderly patient to preserve their body heat.

“I tell seriously injured patients that they are at Vanderbilt, and that they are safe now”.

“I keep patients informed and carefully explain their treatment to them.”

“I turn the TV to the education channel, when it can help them.”

“I tell the patient that it has been my honor to care for them.”

“I use fun band aids or decorate them!”

“I always sit down when I talk to my patients”

“I like to use warm blankets and footies to keep the patient comfortable.”

“I remember to put my name on the white board.”

“Keep a bag of angels. I wear one, and pass them on when I’m asked about them.”

“I ask the patient about their family, pets, etc. to personalize the relationship.”

“I teach the patient about taking their BP and make sure they understand their meds.”

“I give patients a foot massage if they have had a long wait”

“I spend as much time as possible using comfort measures, propping patient.”

Jay Kaplan, M.D., F.A.C.E.P.  
ATTENDING EMERGENCY PHYSICIAN  
BOARD CERTIFIED IN EMERGENCY MEDICINE

Marin General Hospital  
250 Bon Air Road  
Greenbrae, CA 94904

ED phone: 415.925.7200  
vocemall: 415.258.4875  
jaykaplan@cep.com  
www.cepamerica.com

At the Marin General Hospital Emergency Department  
we are genuinely concerned about your health and your comfort.

We commit to keeping you informed about your care.  
Our mission is to care for you in an outstanding and compassionate way, answer your questions, and explain all procedures and treatments.

Thank you for giving us the privilege of caring for you.  
I hope that we have provided you with VERY GOOD care.
Simple Truth #2: We All Believe We Give Great Service

We assume

Patient Satisfaction = Employee Satisfaction

Simple Truth #3: We think we’re doing better than we actually are . . .
What is Excellent Physician Communication?

- The physician listened (RR 1.8; 95% CI 1.0 – 2.5; p< .001)
- The patient got as much medical information as they wanted (RR 1.6;95% CI 1.1 – 1.9; p< .001)
- The patient was told what to do if symptoms continued, worsened or returned (RR 1.4; 95% CI 1.2 – 1.5; p<.001)
- The patient spent as much time as they wanted with their physician (RR 1.8; 95% CI 1.3-2.2;p<.001)


Provider Communication . . . Really?

Physician Communication When Prescribing Medications:  
*(Arch of Internal Med, 2006)*

- 26% failed to mention the name of a new medication
- 13% failed to mention the purpose of the medication
- 65% failed to review adverse effects
- 66% failed to tell the patient duration of treatment

The Golden 2 Minutes

- 74% of patients are interrupted by providers when giving their initial history in an average of 16.5 seconds

*(J Gen Int Med, 2005)*
Simple Truth #4: No Rest For The . . .

“If the other guy’s getting better, then you’d better be getting better faster than that other guy’s getting better . . . or you’re getting worse.”

-- Tom Peters
The Circle of Innovation

What Does All This Mean For Us?

- There’s a lot of work to do.
- We have to assure engagement before we can expect alignment.
- You can’t get Quality as a group if everyone is not on board, which means . . .
- We all need to recommit and understand “No more reserved seats on the bus.”
- With the measurement feedback you get (ask for it!!), if you personally are not at the mean or above, get going.
The Big Question

How can you, as a medical staff, create a consistent experience for your patients and their families, despite your:
- Varied backgrounds
- Diversity
- Different years of experience
- Different styles

Especially given the fact that any patient may see 3-5 different members of your medical staff (or more) during one hospital stay???

Action – Think Process Outcomes

Think Bowling . . .

- Set up pins (goals)
- Follow through
- Keep score

- Determine metrics
- Define baselines
- Create action plans
Potential “Pins”

- Door to Doc time
- Door to Room
- Room to Doc
- TAT Lab/Imaging
- Order admission to patient to floor
- LWOT’s
- % Patients discharged before noon

Focus on Systems - Getting Patients In

- Quick Registration
- Immediate Bedding
- RME: Treat-&-Street from Triage/Initiate Care on Others
- Advanced Nurse Interventions

- Door to Doc
- Patient Sat
Key Principles

- “Intake” not “Triage”
- If you can’t get the patient back to the provider, get the provider out to the patient
- Parallel not sequential (whenever possible)

Systems - While Patients Are In

- Service goals for Lab, Imaging and Consultants
- All rooms multi-purpose
- Chairs instead of stretchers
- Extenders
- Charge Physician
- Board Rounds
### Key Principles

- Charge or Lead physician
- Board rounds
- Stretchers are “leased” not “owned”

### Create Your Scorecard/Action Plan

<table>
<thead>
<tr>
<th>Service</th>
<th>Metric</th>
<th>Baseline</th>
<th>Goal</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction - Overall percentile</td>
<td>85%ile</td>
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<tr>
<td>Patient Satisfaction - Physician section percentile</td>
<td>85%ile</td>
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<tr>
<td>Patient Satisfaction - Nurse (or other key) section percentile</td>
<td>85%ile</td>
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<td>Discharge phone calls % contacted</td>
<td>60%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality</th>
<th>Metric</th>
<th>Standard</th>
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<th>MAR</th>
<th>APR</th>
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<tbody>
<tr>
<td>Patient Arrival to Bed</td>
<td>15 min</td>
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<tr>
<td>Bed to Physician/MPW</td>
<td>15 min</td>
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<td>Length of Stay Times</td>
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<td>ED Discharges</td>
<td>150 min</td>
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<td>ED Fast Track Pts</td>
<td>60 min</td>
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<td>Door to Pain Medication</td>
<td>10 min</td>
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<tr>
<td>Admit order to patient leaves ED for inpatient bed</td>
<td>60 min</td>
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<td>Patients being boarded - 8 and hours</td>
<td>0/0</td>
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<tr>
<td>Core measures – Acute MI - PC within 90 minutes</td>
<td>100%</td>
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<tr>
<td>Core measures – CAP - Antibiotics within 6 hour</td>
<td>100%</td>
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<td>Inpatient metric - % Patients Discharged by 12 noon</td>
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Make Your Data Public

Strategies to Improve Quality

- Pro-Active
  - Leader Rounding
  - Discharge Follow-Up Phone Calls
- Performance Improvement
- Six Sigma
- Lean
Leader Rounding on Staff

**Harvest Wins:**
“Are there any staff or physicians you would like me to compliment or recognize?”

**Focus on the Positive:**
“What is going well today?”

**Identify Process Improvement Areas:**
“What systems could be working better?”

**Repair and Monitor Systems**
“Do you have the tools, equipment and assistance to care for your patients well?”

**Coach on New Behaviors**
“We’re trying to improve our patients’ experience. One way to do that is . . . “

Rounding in the ED

**Nurse Leader** round each shift on employees
**MD Leader** round once weekly on MDs and patients, connecting the dots
**Clinical Leaders** round every 4 hours on patients and staff, connecting the dots
**Technical staff** round frequently at discretion of Charge RN to do “comfort rounds”
**Rounding in reception area** (decrease your LNS)
Leader Rounding on Patients

Old Vs. New Paradigms of Patient Contact

Old Way: See the patient, order your diagnostic tests, wait for all the results to come back, go tell the patient what you found.

New Way: Touch base with your patient as often as possible, no less than every 30 mins. As results return, advise the patient.

“Pollinate the Rooms”
Patient Perception → Quality

Shadow Rounding With Physicians

Hi;
In our continuing effort to improve our patient satisfaction and thus improve the quality of our care we are now shadowing doctors for two patient visits. The purpose of our rounding is to gain insight into the patients' perceptions of their interaction with you. We can then give you feedback for your own education—this is not meant in any way to be judgmental or critical of you—as to ways you may change your interaction with patients. Again, this shadowing is not a pass/fail test; it is designed to give feedback to you that you may find helpful in understanding how to improve your patient satisfaction and thus optimize patient outcomes.
How To Complete the Patient Experience: Follow Up Phone Calls


• 78% did not have full understanding
• 80% of that 78% did not understand that they did not understand

---

Post Visit Calls

**Likelihood of Recommending - ED**

![Bar chart showing likelihood of recommending ED.](chart.png)

Source: *New Jersey Hospital, Total beds = 775; 3Q2007 – 2Q2010*
Improves Physician Performance...
(January-June 2008, Press Ganey National %tile rank)

- Doctors Section
  - 97th percentile
  - 81st percentile
- Likelihood of Recommending
  - 94th percentile
  - 72nd percentile
  - 51st percentile

Doctors making d/c calls
Other calls being made
No call

Discharge Calls: Improved Clinical Quality

Emergency Department:
Volume Adjusted 24-hour Emergency Department Returns

- Month 1: 2.9%
- Month 2: 2.1%
- Month 3: 2.5%
- Month 4: 1.9%
- Month 5: 2.0%

Source: The Regional Medical Center, South Carolina, Total beds = 286
Follow Phone Calls Summary: 6 Reasons Why

- Quality
- Risk management
- Patients love it
- You will love it (lots of kudos)
- You will be a better clinician
- Decreased return visits/hospital admissions

People - For Our Patients

- Think Bakery
- Sit Down/ICARE
- Rounding on Patients
Key Strategy #1: Think Bakery

What Do Our Patients See?
It’s Cold and Flu Season
If you have fever, chills, headache, body aches, cough, sore throat, sneezing, runny or stuffy nose, please do not visit until you’re well.

Meanwhile, ASK FOR A MASK

EVENtYONE WELCOME EXCEPT GERMS

Washing hands saves lives.

IT IS THE LAW!

IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR,
YOU HAVE THE RIGHT TO RECEIVE
(Within the capabilities of this hospital staff and facilities)
- AN APPROPRIATE MEDICAL SCREENING EXAMINATION,
- NECESSARY STABILIZING TREATMENT
  (Including treatment for an unborn child)
  AND IF NECESSARY
- AN APPROPRIATE TRANSFER TO ANOTHER FACILITY
  EVEN IF YOU CAN NOT PAY
OR
DO NOT HAVE MEDICAL INSURANCE
OR
YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID

ES LA LEY!
Take a Fresh Look – Change the Signs

DeKalb Medical
Emergency Department
Performance Guarantee

As members of DeKalb Medical’s Emergency Team, we are dedicated to working and collaborating together to create:

CLINICAL EXCELLENCE &
EXCEPTIONAL CUSTOMER SERVICE

We will listen to our patients, visitors, and each other. Do the things we say we will. Try our best to do these well every time, and continuously promote a spirit of caring and a learning environment.

We Provide Excellent Care

People Helping People
Patient First

Our Promise

We care about you as a person.
We will keep you comfortable and effectively treat your pain.
We will keep you informed throughout your visit.
We will make sure you understand your diagnosis and what to do after you leave the hospital.
If we fail to deliver on our promise, please let us know during your visit.
Thank you for giving us the privilege of caring for you.
What Do Our Patients Feel?

Sit Down

To Sit or Not to Sit?
(Annals Emerg Med 2007)

- Sitting: time overestimated 15%
- Standing: time underestimated 7%
- Providers overestimated time 6%
What Do Our Patients Hear?

People (Patients) will not hear all of your words . . . Use Key Words or Phrases to express your caring.

Use Key Words

❖ “For your safety”
❖ “For your privacy”
❖ “For your comfort”
❖ “To keep you informed”
❖ “Let me go over what the nurse has written so you don’t have to repeat yourself all over again - we work together as a team.”
❖ “What questions do you have? Is there anything I can do for you right now?”
Key Strategy #2: Do Not Assume Our Patients Know . . .

- Who we are;
- How good we are;
- How much we care
- How long some process takes;
- What the process will involve;
- What will follow.

Communication Strategy: Think Baseball - Touching All the Bases
**Five Fundamentals of Communication**

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<tr>
<th>I</th>
<th>Introduce</th>
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<td>C</td>
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<td>Educate</td>
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- **Introduce** self with title, Service recovery if needed, **Inspire** confidence
- **Connect** - with the patient & family, **Contact** – Verbal/Physical/Non-Medical
- **Acknowledge** what the patient has said, **Articulate** what you have found and what you think is going on - Use Key Words
- **Review** the plan of care, what tests and treatments are to be accomplished, and **Remember** to say how long it is going to take → **Under-Promise and Over-Deliver**
- **Educate** What to Expect/Home Care, **Ensure** Understanding-Ask “What questions do you have? Is there anything else I can do for you?”, **Express** Gratitude
<table>
<thead>
<tr>
<th>A</th>
<th>Acknowledge patient and family, smile, Contact – Eye, Verbal, Physical, Non-medical, Use Key Words</th>
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<tbody>
<tr>
<td>I</td>
<td>Introduce self with title, Manage Up, (Inspire confidence), Service Recovery if needed</td>
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<td>Explain Duration - how long evaluation and diagnostic work-up will take, and how long the healing process is expected to take, Under-Promise and Over-Deliver</td>
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<td>E</td>
<td>Explain your understanding &amp; ask for theirs, Mention findings on physical exam, Discuss the plan of care, Ensure Understanding</td>
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<td>Thank the patient and Say good-bye Create Closure</td>
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**Rounding on Patients by Staff**

- Touch base with your patients at least every 30 minutes
- Address PPD – Pain, Plan of Care and Duration (*wait times*)
- When at the bedside, assess additional comfort needs. (*warm blanket, pillow, etc*)
- If you get a bolus of patients in at one time, tell patients you know they are there.
- If the reception area gets unruly, go out and quiet it down (takes 30 seconds).
Physician Rounding

- Old Way: See the patient, order your diagnostic tests, wait for all the results to come back, go tell the patient what you found.

- New Way: Touch base with your patient as often as possible, no less than every 30 mins. As results return, advise the patient.
  
  “Pollinate the Rooms”

Summary – For Our Patients

- Sit Down/ before you get up, use a key phrase

- Think Touching all the bases – ICARE (AIDET)

- Rounding

- Follow Up Phone Calls
Thank you.
Jay Kaplan MD, FACEP
jkaplan@acep.org