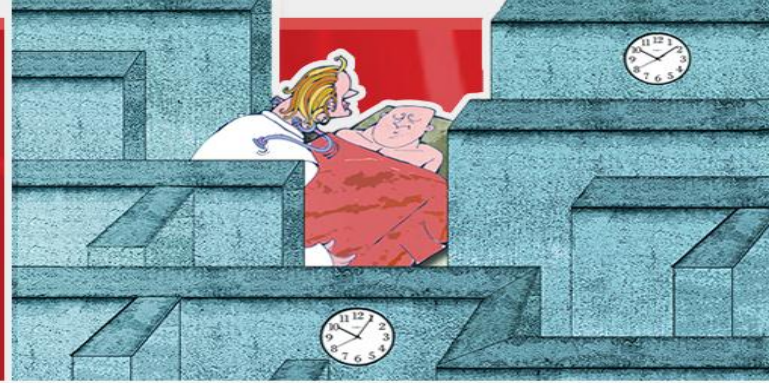


1st INTERCONTINENTAL
Emergency Medicine Congress

15 - 18 May 2014
Gloria Golf Resort Hotel,
Belek-Antalya



ED Management

Key principles

Saleh Fares MD, MPH, FRCPC(EM), FAAEM, FACEP
Founder and President, Emirates Society of Emergency
Medicine (ESEM)

Chair, Emergency Department
Zayed Military Hospital, Abu Dhabi, UAE

Disclosure

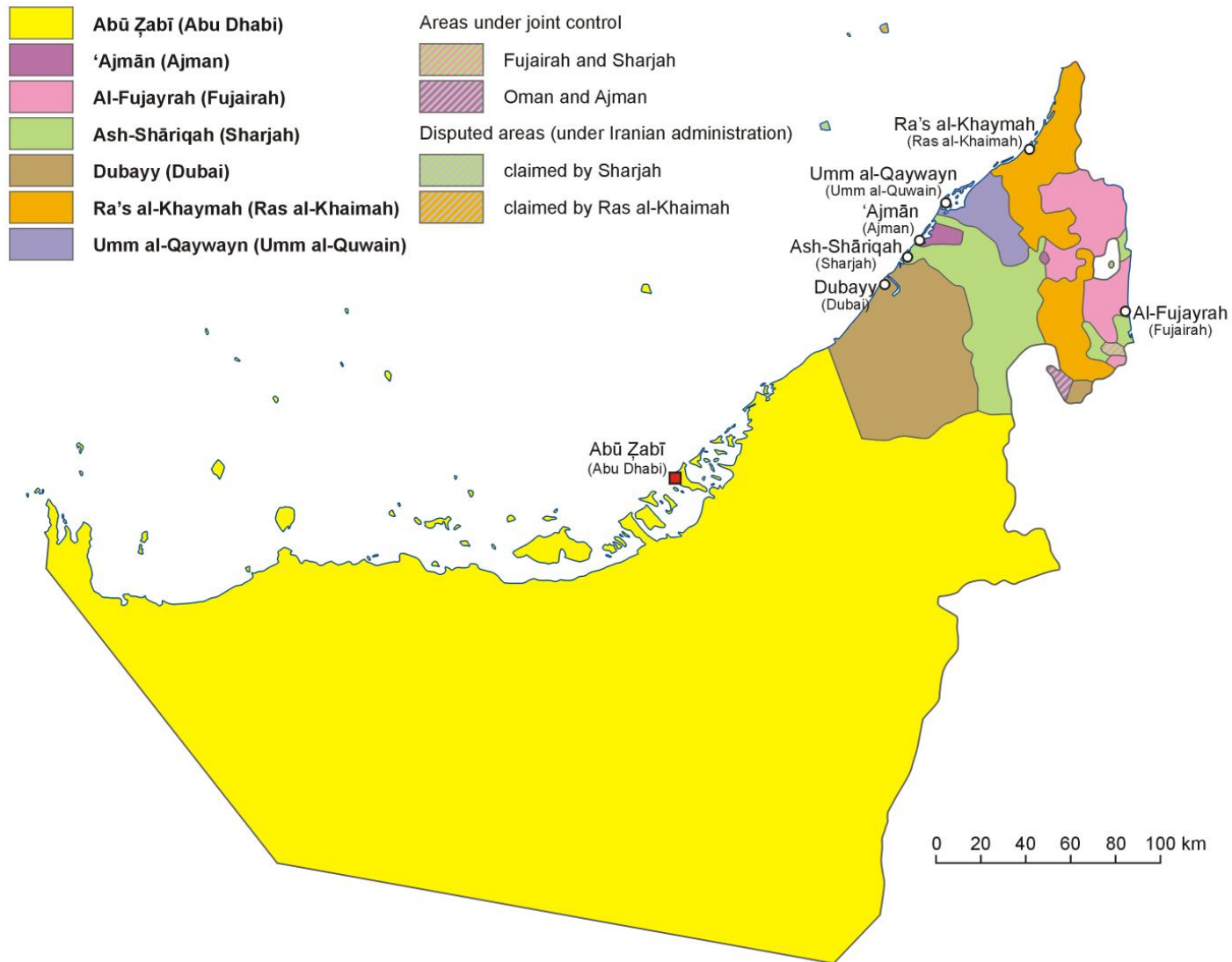
- No conflict of interest

Objectives

- Overview
- Four key components
- Review relevant literature
- Useful resources

Where I'm from?











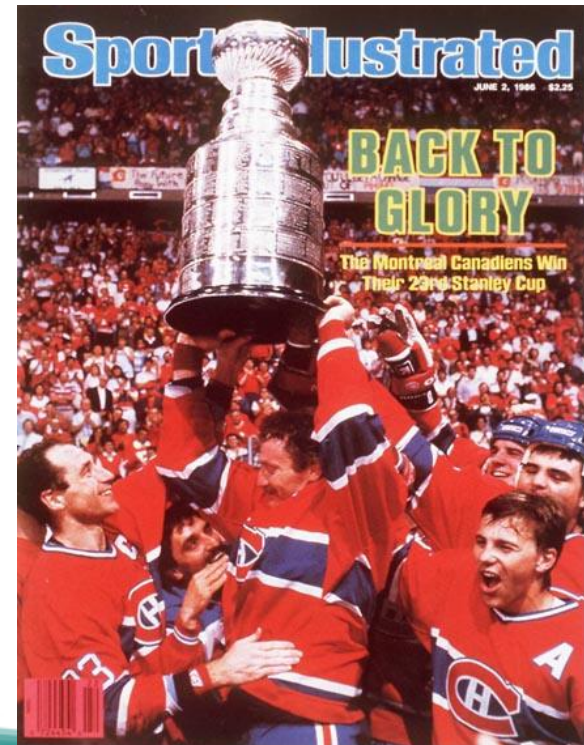
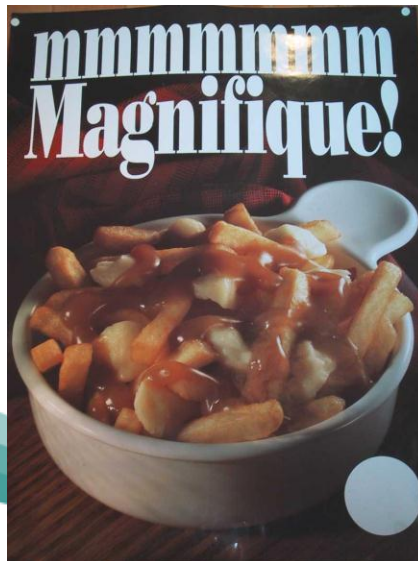
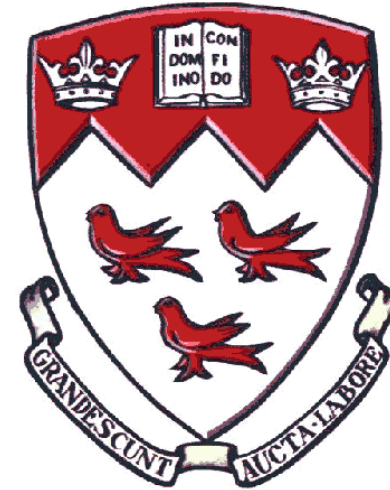


Academic Path

Medical School:



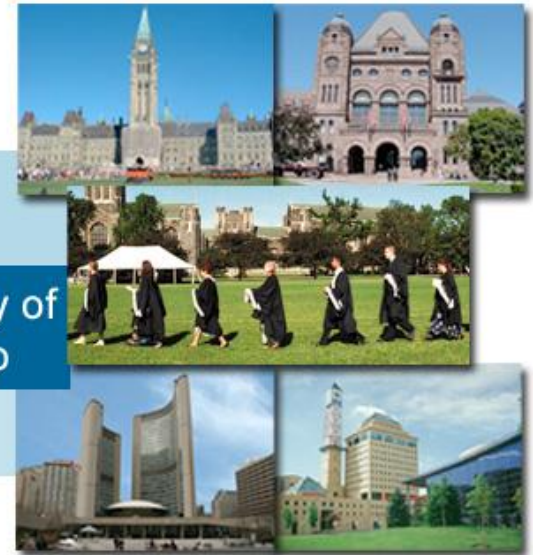
EM Residency...



EMS Fellowship



University of
Toronto



DM Fellowship:



MPH/DrPH Program



JOHNS HOPKINS
UNIVERSITY

If you want a fun EM career..

Come and see me!

Why ED management is Important?

Why?

Advance Data

From Vital and Health Statistics

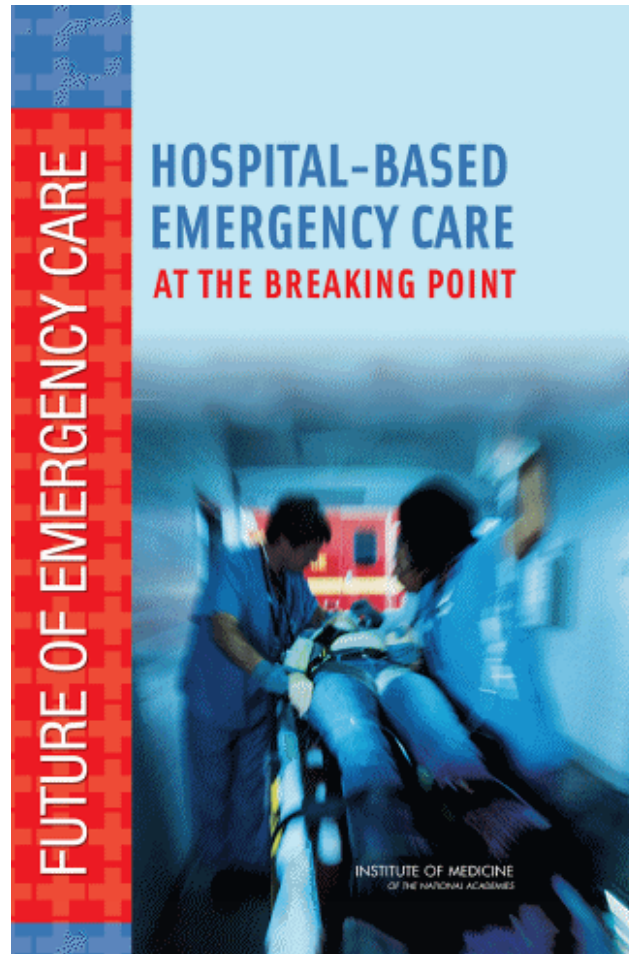


Number 335 • June 4, 2003

National Hospital Ambulatory Medical Care Survey: 2001 Emergency Department Summary

by Linda F. McCaig, M.P.H., and Catharine W. Burt, Ed.D., Division of Health Care Statistics

Why?



Why?

GAO United States Government Accountability Office
Report to the Chairman, Committee on
Finance, U.S. Senate

April 2009

HOSPITAL EMERGENCY DEPARTMENTS

Crowding Continues
to Occur, and Some
Patients Wait Longer
than Recommended
Time Frames



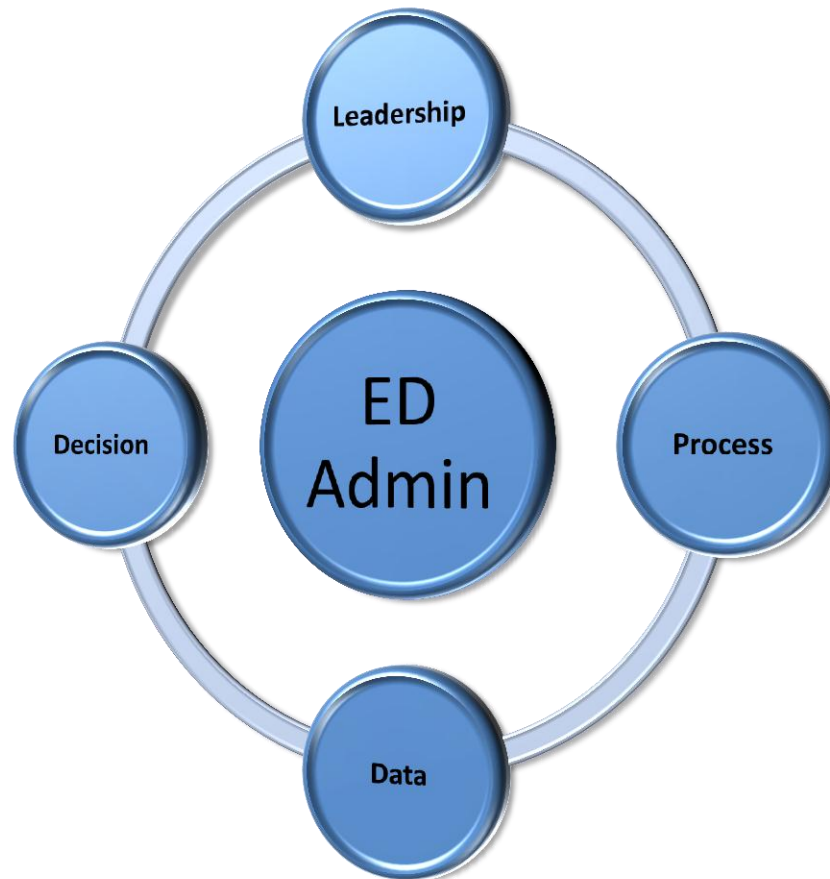
GAO-09-347

Common problem

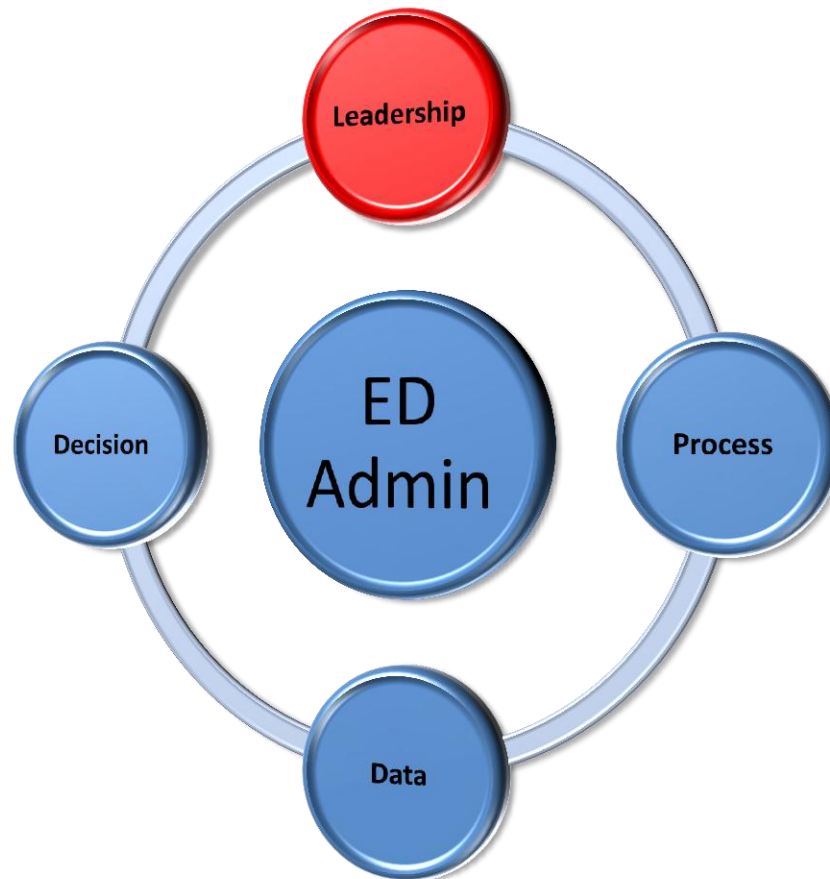
- Overcrowding
- Waiting time
- Understaffing
- Boarded patients
-

Think ED like a business

Key components



Key components



Leadership



Leadership



Leadership



Leadership

- Leader vs. manager
- Building a team

Leadership



Leadership

- Management skills
 - Vision
 - Hiring and firing
 - Good meetings
 - Execution



Leadership

- Management skills
 - Vision
 - Hiring and firing
 - Good meetings
 - Execution
 - Staff satisfaction



Business-Unit-Level Relationship Between Employee Satisfaction, Employee Engagement, and Business Outcomes: A Meta-Analysis

James K. Harter
The Gallup Organization

Frank L. Schmidt
University of Iowa

Theodore L. Hayes
U.S. Immigration and Naturalization Service

Based on 7,939 business units in 36 companies, this study used meta-analysis to examine the relationship at the business-unit level between employee satisfaction–engagement and the business-unit outcomes of customer satisfaction, productivity, profit, employee turnover, and accidents. Generalizable relationships large enough to have substantial practical value were found between unit-level employee satisfaction–engagement and these business-unit outcomes. One implication is that changes in management practices that increase employee satisfaction may increase business-unit outcomes, including profit.

Peer review

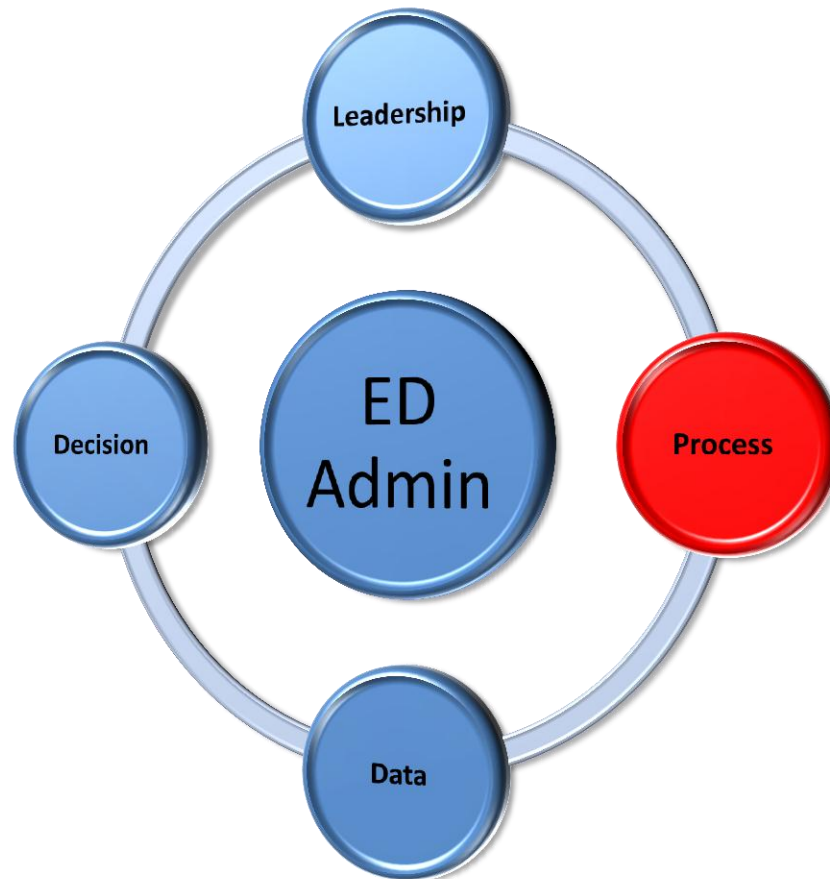


Core Competencies

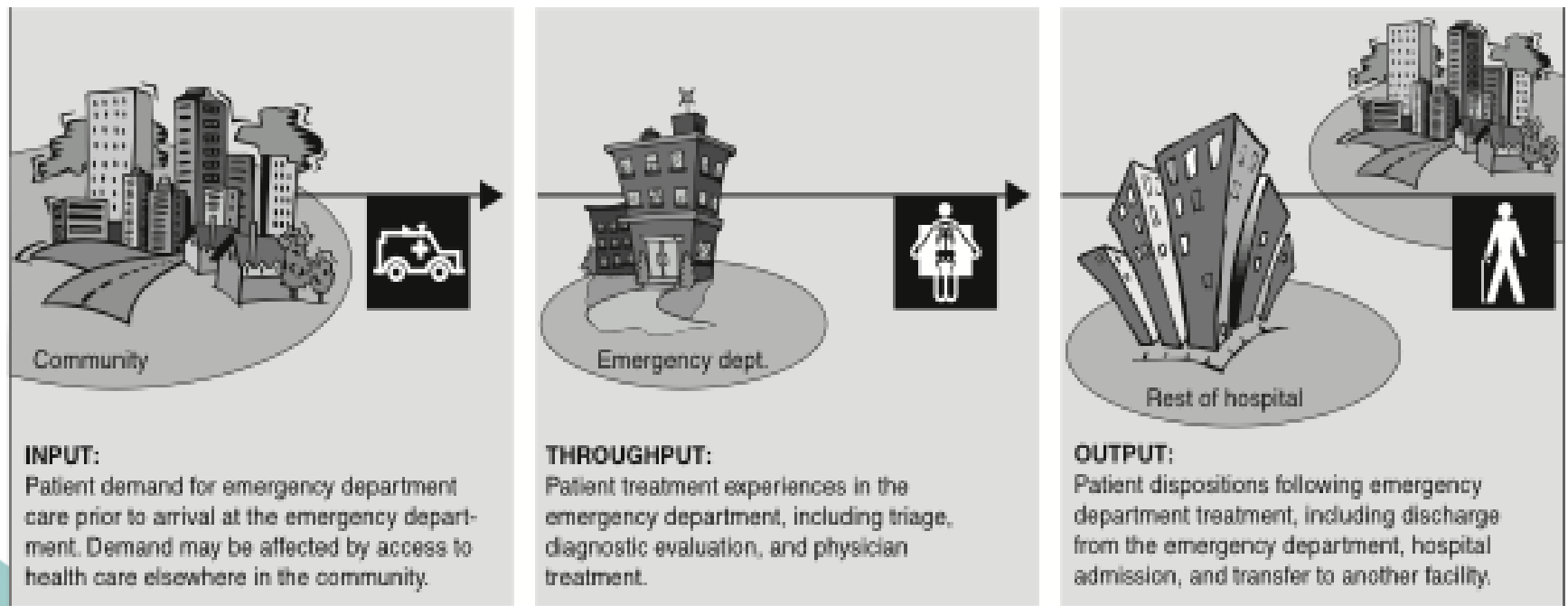
- Patient Care
- Medical/Clinical Knowledge
- Practice-Based Learning and Environment
- Interpersonal and Communication Skills
- Professionalism
- System-based Practices



Key components



Process



Source: GAO analysis of published literature, Art Explosion (graphics).

Process - Input

THE PRACTICE OF EMERGENCY MEDICINE/CONCEPTS

Optimizing Emergency Department Front-End Operations

Jennifer L. Wiler, MD, MBA
Christopher Gentle, MD
James M. Halfpenny, DO
Alan Heins, MD
Abhi Mehrotra, MD
Michael G. Mikhail, MD
Diana Fite, MD

From the Division of Emergency Medicine, Washington University in St. Louis School of Medicine, St. Louis, MO (Wiler); the Department of Emergency Medicine, Christiana Care Health Services, Newark, DE (Gentle); Forrest Hills Hospital, Forrest Hills, NY (Halfpenny); the Department of Emergency Medicine, University of South Alabama College of Medicine and Medical Center, Mobile, AL (Heins); the Department of Emergency Medicine, University of North Carolina, Chapel Hill, NC (Mehrotra); the Department of Emergency Medicine, St. Joseph Mercy Hospital, Ann Arbor, MI (Mikhail); and the Department of Emergency Medicine, University of Texas Medical School at Houston, Houston, TX (Fite).

As administrators evaluate potential approaches to improve cost, quality, and throughput efficiencies in the emergency department (ED), “front-end” operations become an important area of focus. Interventions such as immediate bedding, bedside registration, advanced triage (triage-based care) protocols, physician/practitioner at triage, dedicated “fast track” service line, tracking systems and whiteboards, wireless communication devices, kiosk self check-in, and personal health record technology (“smart cards”) have been offered as potential solutions to streamline the front-end processing of ED patients, which becomes crucial during periods of full capacity, crowding, and surges. Although each of these operational improvement strategies has been described in the lay literature, various reports exist in the academic literature about their effect on front-end operations. In this report, we present a review of the current body of academic literature, with the goal of identifying select high-impact front-end operational improvement solutions. [Ann Emerg Med. 2010;55:142-160.]

Process - Throughput

The Impact of Input and Output Factors on Emergency Department Throughput

Phillip V. Asaro, MD, Lawrence M. Lewis, MD, Stuart B. Boxerman, DSc

Abstract

Objectives: To quantify the impact of input and output factors on emergency department (ED) process outcomes while controlling for patient-level variables.

Methods: Using patient- and system-level data from multiple sources, multivariate linear regression models were constructed with length of stay (LOS), wait time, treatment time, and boarding time as dependent variables. The products of the 20th to 80th percentile ranges of the input and output factor variables and their regression coefficients demonstrate the actual impact (in minutes) of each of these factors on throughput outcomes.

Results: An increase from the 20th to the 80th percentile in ED arrivals resulted in increases of 42 minutes in wait time, 49 minutes in LOS (admitted patients), and 24 minutes in ED boarding time (admitted patients). For admit percentage (20th to 80th percentile), the increases were 12 minutes in wait time, 15 minutes in LOS, and 1 minute in boarding time. For inpatient bed utilization as of 7 AM (20th to 80th percentile), the increases were 4 minutes in wait time, 19 minutes in LOS, and 16 minutes in boarding time. For admitted patients boarded in the ED as of 7 AM (20th to 80th percentile), the increases were 35 minutes in wait time, 94 minutes in LOS, and 75 minutes in boarding time.

Conclusions: Achieving significant improvement in ED throughput is unlikely without determining the most important factors on process outcomes and taking measures to address variations in ED input and bottlenecks in the ED output stream.

ACADEMIC EMERGENCY MEDICINE 2007; 14:235-242 © 2007 by the Society for Academic Emergency Medicine

Keywords: crowding, hospital emergency services, bed occupancy, patient care, regression analysis

Process - ED Design



Process



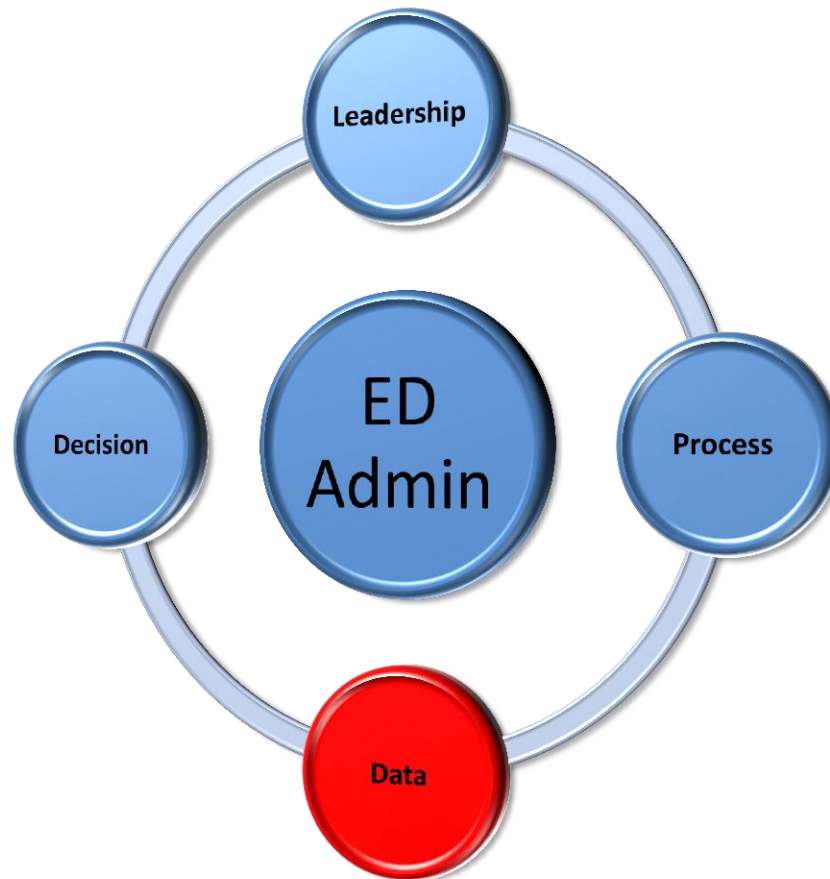
Patients satisfaction

- Good team
- Courtesy
- Time to Listen
- Informative
- Concern for Comfort

Patients satisfaction

- Complaints:
 - Harm
 - Mistreatment
 - Didn't meet expectations

Key components



Data

If you cannot measure it.....
you cannot manage it.....

Data

ARTICLE IN PRESS

HEALTH POLICY/CONCEPTS

Emergency Department Operational Metrics, Measures and Definitions: Results of the Second Performance Measures and Benchmarking Summit

Shari J. Welch, MD, Brent R. Asplin, MD, MPH, Suzanne Stone-Griffith, RN, MSN, Steven J. Davidson, MD, MBA, James Augustine, MD, Jeremiah Schuur, MD, MHS

*From the Intermountain Institute for Health Care Delivery Research, Salt Lake City, UT (Welch); Department of Emergency Medicine, Mayo Clinic College of Medicine, Rochester, MN (Asplin); Emergency Services, EMS and Traum, HCA-Continental Division, Nashville, TN (Stone-Griffith); Maimonides Medical Center, Brooklyn, NY (Davidson); EMP, Canton, Ohio, and Department of Emergency Medicine, Wright State University, Dayton, Ohio (Augustine); Department of Emergency Medicine, Brigham & Women's Hospital, and Harvard Medical School, Boston, MA (Schuur), for the Emergency Department Benchmarking Alliance.**

There is a growing mandate from the public, payers, hospitals, and Centers for Medicare & Medicaid Services (CMS) to measure and improve emergency department (ED) performance. This creates a compelling need for a standard set of definitions about the measurement of ED operational performance. This Concepts article reports the consensus of a summit of emergency medicine experts tasked with the review, expansion, and update of key definitions and metrics for ED operations. Thirty-two emergency medicine leaders convened for the Second Performance Measures and Benchmarking Summit on February 24, 2010. Before arrival, attendees were provided with the original definitions published in 2006 and were surveyed about gaps and limitations in the original work. According to survey responses, a work plan to revise and update the definitions was developed. Published definitions from key stakeholders in emergency medicine and health care were reviewed and circulated. At the summit, attendees discussed and debated key terminology and metrics and work groups were created to draft the revised document. Workgroups communicated online and by teleconference to reach consensus. When possible, definitions were aligned with performance measures and definitions put forth by the CMS, the Emergency Nurses Association Consistent Metrics Document, and the National Quality Forum. The results of this work are presented as a reference document. [Ann Emerg Med. 2010;xx:xxx.]

Data

Blank Database \ Worksheet 1 \

MIDDLE EAST EMERGENCY DEPARTMENT BENCHMARKING

Identifier <input type="text"/>	<input type="radio"/> EHR Yes	<input type="radio"/> UC Yes	<input checked="" type="radio"/> Yes Pediatrics	<input type="radio"/> OB-GYN Yes	<input type="radio"/> Obs Unit Yes
	<input type="radio"/> EHR No	<input type="radio"/> UC No	<input checked="" type="radio"/> No Pediatric	<input type="radio"/> OB-GYN No	<input type="radio"/> Obs Unit No
Hospital Type <input type="text"/>	Bedsp <input type="text"/>	Fast Track <input type="text"/>	OBS Beds Number <input type="text"/>		
ED Visit Volume <input type="text"/>	OB volume % <input type="text"/>	Pediatric Volume % <input type="text"/>	Live Tracking <input type="text"/>	Ambulance Arrivals % <input type="text"/>	

Number of Doctors Total <input type="text"/>	Daily Doctor Hours <input type="text"/>	Percent Admissions <input type="text"/>	<div style="background-color: yellow; padding: 5px; border: 1px solid black; margin-bottom: 5px;">Quality Indicators</div> <div>Time to Antibiotics Sepsis <input type="text"/></div> <div>Time to Antibiotics HCAPS <input type="text"/></div> <div>Time to Aspirin MI <input type="text"/></div> <div>Time to CT Stroke <input type="text"/></div> <div>Time to CT Trauma <input type="text"/></div> <div>Door to Balloon or to Needle <input type="text"/></div>
Patient per Provider Hour Rat <input type="text"/>	RVU per Clinical FTE <input type="text"/>	Patient Satisfaction <input type="text"/>	
LOS <input type="text"/>	Door to Doctor <input type="text"/>	% AMA <input type="text"/>	
			% LWBS <input type="text"/>

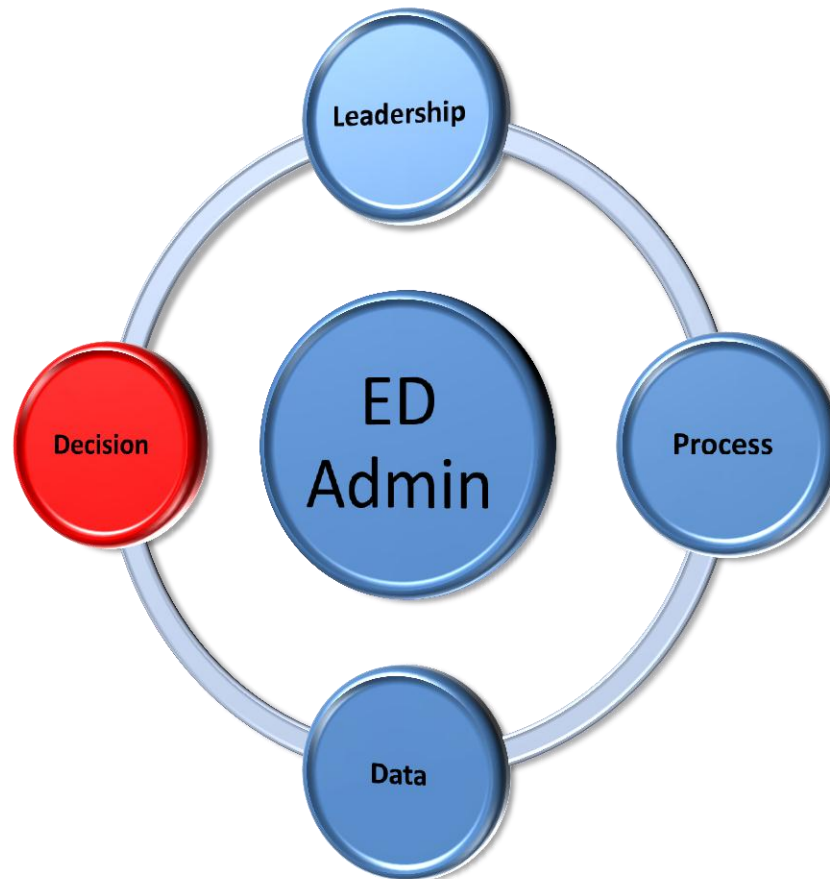
W: 8.25 H: 10.55 | 100% Design | Blank Database

Data



Educating and Connecting

Key components



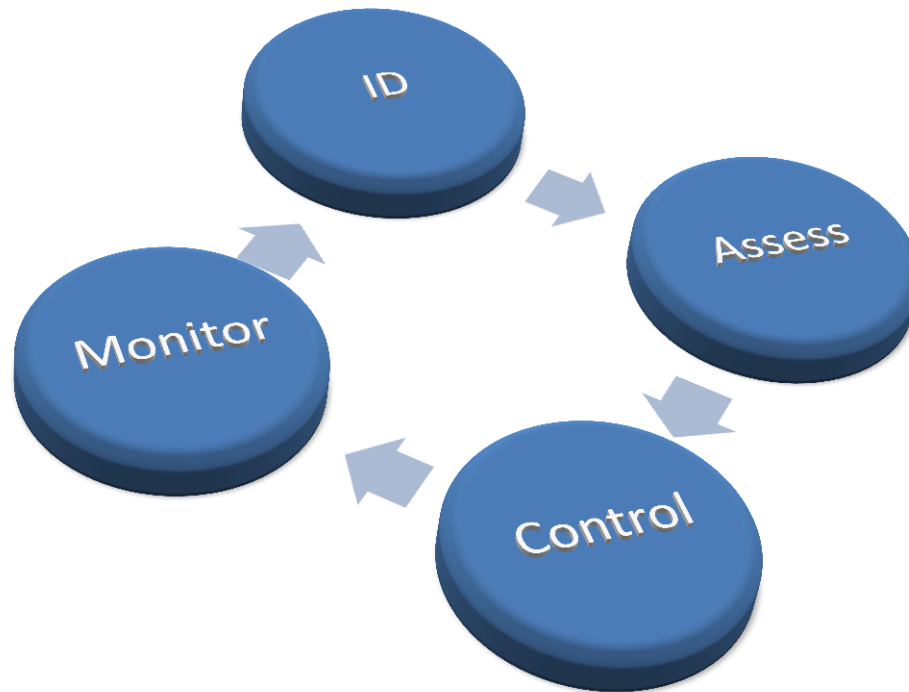
Decision



Decision

- Logistics
- Human resources
- Finances
- Relationships
- Medicolegal

Risk management:



Risk management:

- Patient safety
- Documentation
- Discharge instructions
- Clinical Practice Guidelines
- Communication
- Handover

ECC Report to Floor Form

1. This form is to be used on all patients admitted to the hospital.
2. Callist report is to be accepted form. If the accepting nurse is unavailable, the reporting nurse will complete this form, notify the charge nurse of receiving floor and take the form to the accepting floor (exception is Pediatric, due to 30000). The charge nurse will review and if questions arise, will call the reporting nurse for verbal communication. If no call has been received within fifteen minutes, the reporting nurse will assume the admission is appropriate and transfer the patient to the assigned room. The Charge Nurse may request the patient to be held briefly for code 44, Rapid Response or Dr. Irving on unit.

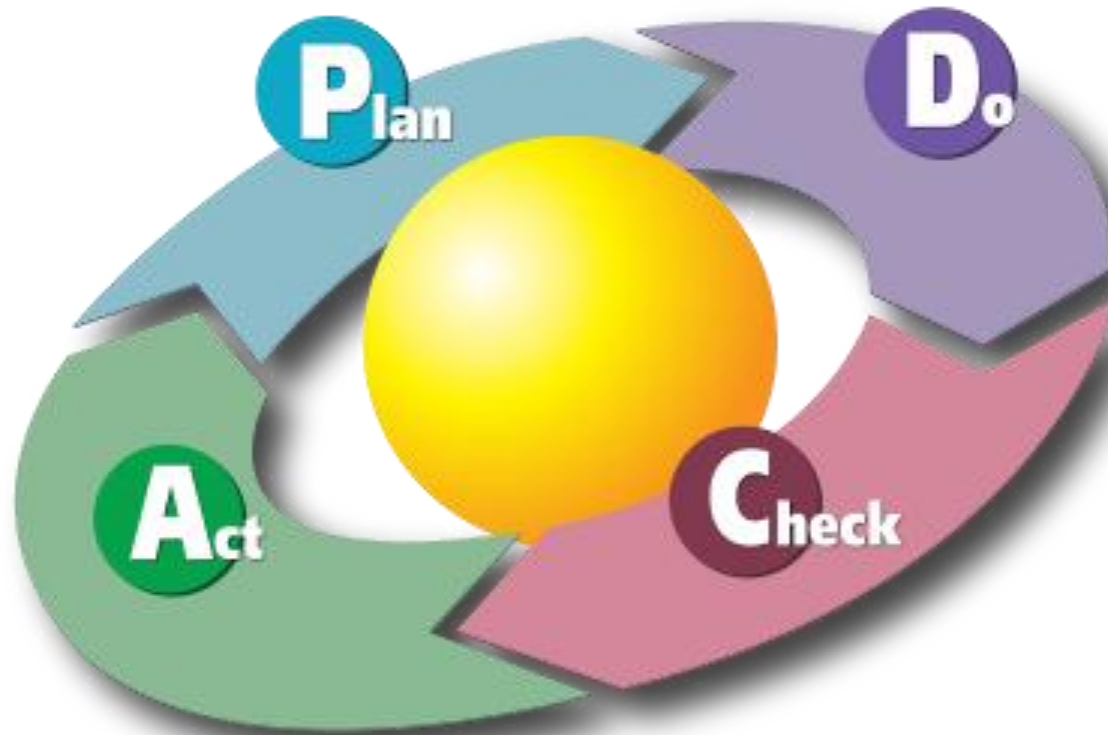
3. THIS FORM CANNOT BE USED FOR ICU TRANSFERS

S	E.C.C. Room: _____ Admit Room: _____		On: _____
	Patient's Name: _____		PCP: _____
B	Current Vital Signs: T: _____ P: _____ R: _____ BP: _____ SaO ₂ : _____ Pain Scale: _____		Adm. Status: () Obs () Full Allergies: () NONE () LIST DNR: () Yes () No () Unknown
	Visual confirmation of I.D. and Allergy bracelets: () Y () N		
A	Signatures () Nurse () CAD Wt: _____ lbs. Kgs: _____ () NEDM () COPD Initial Lab Draw: _____ () EDNA () ASTROGA Cardiac Markers: 0 1 2 () CSE () OTHER: _____ () JH () L.V. Site: _____ () Tach/Brace (H-O A & B ONLY) E.V. Site: _____ () Medications given to E.C.C. Inserted: PTA E.C.C. _____		CRITICAL LAB VALUES () WBC () LIVER () LYTES () RENAL () IN & R () CAESAC () GLUCOSE () OTHER: _____
	Total, Depressant and Delirium must not exceed 3 mg and must be non-sedative. Contraindications listed must go to DMC or ICU. Cardiac and Neuro must go to ICU or DMC.		
R	ADDITIONAL CARDIAC: NSE IS ST A-FIB FLUTTER ECTOPY: PVC's PAC's _____ Other: _____ Abnormal peripheral pulses: yes no If yes, describe: _____ NEURO: Mental status A-O-X Confused Confabulate Alzheimer's Unresponsive Other: _____ PULMONARY: Abnormal findings: _____ GI: Nausea Vomiting Diarrhea GI Bleed Other: _____ GU: Catheter Insertion Foley Placed PTA ECC Other: _____ PSYCHOSOCIAL: _____ CUSTOMER SERVICE: _____ Need the Service Recovery: () Y () N		
	Recommendations See Physician Order Sheet: _____ Immediate Needs: _____ Next Labs Due: _____ Antibiotics: () Y () N Given: () Y () N Time: _____		

Reporting Nurse: _____ Contact number: _____ Receiving Nurse: _____ TIME: _____

Signature **MUST** be legible with last name and credentials.

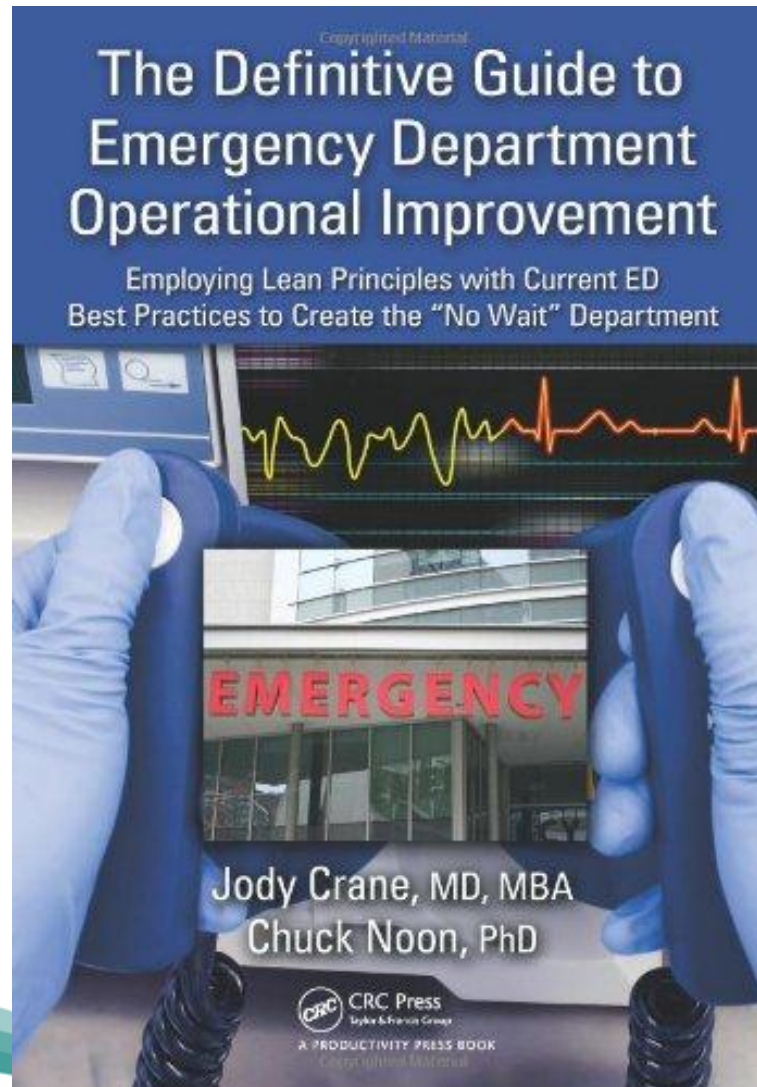
Quality



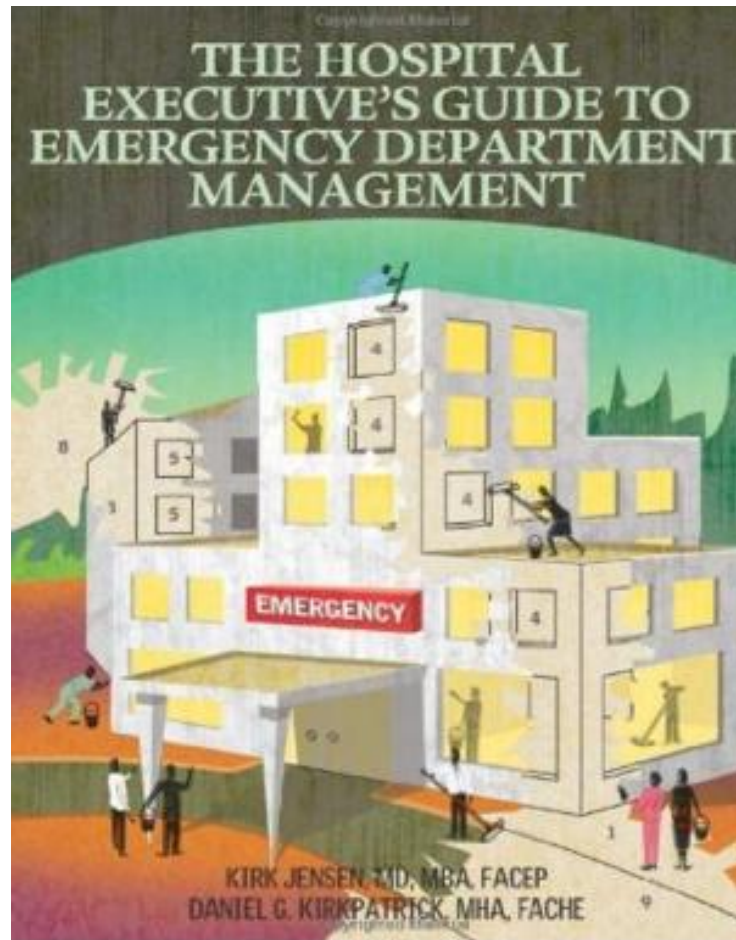
**Success is the ability to go from
one failure to another with no
loss of enthusiasm...**

**Sir Winston Churchill
(1875-1965)**

References



References



References

The screenshot displays the ACEP website's 'Clinical & Practice Management' section. The header includes the ACEP logo, navigation links (Join ACEP, My ACEP, Account Settings, Welcome Guest, Login), and a search bar. The main navigation bar lists various categories: Clinical & Practice Management, Continuing Education, Professional Development, Meetings & Events, Advocacy, Membership, and Bookstore. The breadcrumb trail shows 'Clinical & Practice Management > Clinical Policies'. A large banner image shows a hand using a stethoscope, with the text 'Clinical & Practice Management' overlaid. Below the banner, a sidebar on the left lists 'Clinical & Practice Management' with sub-links for 'Clinical Policies', 'Policy Statements', and 'Residency Programs'. The main content area is titled 'ACEP Clinical Policies' and contains text about board-approved documents and a link to download Adobe Reader 9.1. A 'Related Links' sidebar on the right lists 'Clinical policies' and a specific policy on 'Blunt Abdominal Trauma'. An 'Additional Resources' section is also present at the bottom right.

American College of
Emergency Physicians®
ADVANCING EMERGENCY CARE

Join ACEP | My ACEP | Account Settings | Welcome Guest, Login

Home | News Media | Contact Us | About Us

Clinical & Practice Management | Continuing Education | Professional Development | Meetings & Events | Advocacy | Membership | Bookstore

Clinical & Practice Management > Clinical Policies

Print | Email | ShareThis

Clinical & Practice Management

Clinical & Practice Management

- Clinical Policies
- Policy Statements
- Residency Programs

ACEP Clinical Policies

These ACEP Board-approved documents describe ACEP's policies on the clinical management of emergency department patients.

If you are having trouble viewing these documents, [download Adobe Reader 9.1](#).

Related Links

- Clinical policies
- » ACEP Clinical Policy: Blunt Abdominal Trauma

Additional Resources

Save the Date

5 - 9 December 2014

www.esem2014.com

