The Road to Emergency Department Excellence: How the New Standardized Metrics Can Help Us Transform Our Industry

In September of 2011, nine prominent healthcare provider associations released a final consensus statement and standardized definitions for key emergency department metrics. They are:

- American Academy of Emergency Medicine
- American Academy of Pediatrics
- American Association of Critical-Care Nurses
- American College of Emergency Physicians
- American Nurses Association
- Association of periOperative Registered Nurses
- Emergency Department Practice Management Association
- Emergency Nurses Association
- National Association of EMS Physicians

While the metrics themselves are not new, the standardization part is. This is a significant milestone for the industry as a whole, for individual hospitals, and of course, for the patients who will ultimately benefit from emergency department efforts to improve these time stamps and intervals.

Why Standardized Emergency Department Metrics Matter

First of all, standardized emergency department metrics save lives. Agreeing on the meaning of time stamps and time intervals gives us a more precise vocabulary for solving issues. Knowing that “triage time” means something specific—and isn’t being used interchangeably with, say, “arrival time”—lets us accurately compare our performance with that of others. When we know the national average for reaching a particular time stamp, we can work toward achieving it ourselves.

Standardization also gives our industry a basis for apples-to-apples comparison. In the same way that HCAHPS allows hospitals to nationally compare their patient experience data, these metrics will allow us to see how our emergency departments stack up against others. That’s the starting point for our efforts to share best practices for improvement.

Ultimately, of course, these metrics will set the stage for public reporting of emergency department data. Because a portion of the Centers for Medicare & Medicaid Services (CMS) reimbursement will likely be directly linked to how efficiently hospitals process and treat the roughly 50-60 percent of admitted patients who come in their “front door,” we’ll see more and more focus on streamlining the emergency department experience.
Of course, improving emergency department metrics isn’t just a financial issue. It’s a human issue. In fact, it’s often a matter of life or death. Even emergency departments performing at or near the national average on any given metric have an implied mandate to streamline their operations to become faster and more efficient. That’s because in critical care situations, seconds count.

Consider the interval between arrival time and triage time, for instance. At the average hospital, nine or ten minutes will elapse between arrival time (when the patient talks to a greeter and has her name recorded on a list) and triage time (when the patient is actually evaluated by a triage nurse). And at some hospitals, the time span is far longer.

Studer Group recommends aiming for an interval of five minutes or less between arrival time and triage time. That’s because it’s risky for certain patients to wait too long to see a triage nurse. A heart attack patient who doesn’t fit the typical profile or present with typical symptoms can lose heart muscle in the interval between these two events. An alcoholic who has fallen and hit her head may experience a subdural bleed and a neurological crisis during this time.

Streamlining this interval and those between other ED time stamps helps improve an organization’s throughput and flow. It relieves overcrowding and shortens waiting times, reduces the number of patients who leave without being seen (LWOBS), and sets inpatient staff up for success (which improves both clinical outcomes and employee satisfaction). And, of course, it boosts patient perception of care—there is clear evidence that inpatient satisfaction scores and emergency department satisfaction scores go hand in hand.
1. **Resist the temptation to rationalize poor emergency department performance.** Many organizations just accept crowded emergency departments and long patient wait times as the status quo. They may shrug and say, “Well, it’s the emergency department. *Of course* it’s going to be crowded from time to time—we can’t predict when emergencies are going to happen.” But actually, that’s not true.

While there are always some variables, there is a natural hour-by-hour curve that virtually all emergency departments follow. By doing some simple data mining, we can predict with accuracy when the lulls and peak times will be. We know how many patients on average will arrive every day. What’s more, we know admit rates. If 20 percent will be admitted each day, we can even say how many of them will be intensive care unit patients, how many will be medical-surgical patients, how many telemetry patients, how many pediatric patients, and so forth.

Because we can accurately forecast patient flow, we can plan for mitigating these bottlenecks. And the great news is that we know which tactics will improve the emergency department experience (see pg 4)—very quickly and with minimal expense.

2. **Before implementing tactics, make sure the entire organization is aligned in its goals.** No emergency department is an island. It functions organically with the rest of the organization. Back-ups in the emergency department create problems that cascade into other departments and cause staff members to feel overworked and overstressed. Likewise, inefficiencies in inpatient departments can lead to bed shortages, which can lead to long waits for emergency department patients who are admitted to inpatient units.

This is why shared goals—preferably, objective, measurable, weighted goals that are tied to a leader’s annual performance evaluation and compensation—are so crucial. Organizations must ensure that leaders of interdependent departments—inpatient units, the laboratory, and radiology for instance—have goals that align with those of emergency department leaders.

A simple case in point: If an emergency department leader has a “median time from emergency department admission to arrival on inpatient unit” goal, then inpatient leaders need to carry that goal as well. If they don’t have skin in the game, they won’t feel the same urgency and the organization won’t make progress on improving back end flow.

3. **Realize that less is more.** Too many emergency departments find themselves overwhelmed by numerous tactics that individually produce minimal impact. Studer Group has found it’s better to implement only two to three hard-hitting tactics, each of which yields great ROI in multiple areas.

We find that when an ED implements reception area rounding, it:
- reduces overall length of stay
- reduces door-to-doc times
- reduces patient complaints
- reduces LWOBS

Emergency department leaders and staff members already have tough jobs. By helping them hardwire a few tactics that really make a difference—and that let them see dramatic results quickly—you can make their lives easier and reconnect them to their sense of purpose and passion for the work.
A Few Hard-Hitting Tactics

Studer Group works with emergency departments across the United States and we know which tactics truly get results. Below are three of the most powerful.

**TACTIC 1: Hourly Rounding**

A Studer Group study revealed that rounding every hour in the emergency department reception and treatment areas reduced LWOBS patients by 23.4 percent; decreased patients who left against medical advice (AMA) by 22.6 percent; reduced falls by 54.4 percent; reduced call light usage by 34.7 percent; and 39.5 percent fewer families and patients approached the nursing station. Patient satisfaction also increased between 4 and 20 mean points in all areas measured. What's more, the study found that Hourly Rounding done in conjunction with individualized patient care—responding to the top priority of the patient—was at least 33 percent more effective than Hourly Rounding alone across almost all measures.¹

For partners who have achieved these improvements, Studer Group offers a second generation of tools and tactics that allow them to move results even further.

It is important for staff to focus on pain, plan of care, and duration (PPD) when making hourly rounds. These are top drivers for increasing patient perception of care and should be addressed during each hourly round.

**TACTIC 2: AIDET℠/Key Words at Key Times**

AIDET is a communication framework that improves patients' perception of their care, helps reduce their anxiety (thus improving outcomes), builds their loyalty, and ensures that all healthcare providers are delivering consistent measures of concern and appreciation. The letters of the acronym stand for:

- **Acknowledge**—Acknowledge the patient by name. Make eye contact. Ask: “Is there anything I can do for you?”
- **Introduce**—Introduce yourself, your skill set, your professional certification, and your experience.
- **Duration**—Give an accurate time expectation for tests and physician arrival, and identify/communicate next steps.
- **Explanation**—Explain step by step what will happen, answer questions, and leave a phone number where you can be reached.
- **Thank You**—Thank the patient for choosing your hospital, and for their communication and cooperation. Thank the family for assistance and being there to support the patient.

The consistent use of AIDET makes emergency department staff and providers “memorable” to patients and families and shows care and concern for their well-being during their emergency department stay.

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**TACTIC 3: Key Words at Key Times**

You can supplement AIDET with key words based on the goal you’re trying to meet with any given patient. The words staff members say go a long way toward alleviating many of the anxieties emergency department patients feel.

For example, a triage nurse who wants to keep the patient informed about delays might say, “There is a wait right now, but we will be checking on you frequently (about every hour) to keep you informed and make sure that you are doing okay. Please let me know immediately if you feel worse and I will reassess you.”

When escorting a patient from the waiting room to a hall bed, a nurse might use the key words, “I know your goal is to see the physician as quickly as possible. I don’t have a private room for you just yet, but I am going to place you here in a hall bed so that the physician can see you and get your care started. Please know that we will move you to a private room as quickly as possible and will make every effort to maintain your privacy needs while you are here. If you are more comfortable waiting in the lobby until a private room becomes available, just let me know.”

It’s very powerful to incorporate “me” and “you” into Key Words at Key Times. For example, when we say, “It’s important to me that you have privacy. I’m going to close your curtain to allow for that,” this creates a personal connection with the patient and builds trust and confidence.

Please visit [www.studergroup.com/emergencydepartment](http://www.studergroup.com/emergencydepartment) to learn more about what these and other tactics can accomplish.

### 2011 Standardized Emergency Department Metrics Crosswalk to Patient Expectations and Evidence-Based Tools and Tactics

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DEFINITIONS—TIME STAMPS

EMERGENCY DEPARTMENT
A dedicated location serving an unscheduled patient population requesting emergency assessment.

EMERGENCY DEPARTMENT ARRIVAL TIME*
The time that the patient first arrives at the institution for the purpose of requesting emergency care should be recorded as the arrival time. This is the first contact, not necessarily registration time or the triage time.

*Emergency Medical Services (EMS): EMS vehicle arrives at emergency department door.
*Ambulatory: A patient requests care, or is asked by ED staff if they are here to receive emergency care.

STUDER GROUP TIP: Put a formal process in place for capturing actual arrival time. Greeters, volunteers, security professionals, or nurse expeditors can easily do this job. There is often a lag between patient arrival time and triage time. Try to keep this interval to five minutes or less.

EMERGENCY DEPARTMENT OFFLOAD TIME
Time of transfer of the patient from the EMS stretcher to the ED treatment space with assumption of care by ED staff.

STUDER GROUP TIP: Designate a person on each shift—usually a charge nurse or a radio nurse—to identify placement for all ambulance arrivals. This will decrease ambulance offloading and transfer-of-care time. Aim for an offload time of five minutes or less.

EMERGENCY DEPARTMENT TRANSFER OF CARE FROM PREHOSPITAL PROVIDERS TIME
The time care is accepted by hospital staff.

STUDER GROUP TIP: The designated person mentioned in the offload time recommendation should notify the receiving nurse prior to ambulance arrival. This will expedite the transfer of care. Ideally, the receiving nurse and provider will be present to hear the prehospital report upon arrival.

EMERGENCY DEPARTMENT Triage Time
The time that rapid or comprehensive triage is initiated by a registered nurse or institutionally credentialed provider.

STUDER GROUP TIP: Move to an expedited triage process to reduce patient-arrival-to- triage time. At initial triage, the nurse should gather only five elements of information: patient name, date of birth, social security number, chief complaint, and a full set of vital signs, including pain scale and any known allergies. All other info can be obtained during a secondary assessment. Implementing a “pull until full” or “immediate bedding” process further expedites door-to-doc time. Expedited triage, “pull until full,” and “immediate bedding” are part of the Split Flow Model of Care developed by the Agency for Healthcare Research and Quality (AHRQ) with Banner Health and Arizona State University. See www.studergroup.com/insights for more information.

EMERGENCY DEPARTMENT TREATMENT SPACE TIME*
Time of placement in a treatment space (facility-specific).

*“Treatment space” is any space the hospital/facility accepts as a space to render emergency department care.

STUDER GROUP TIP: Hardwire a process for documenting this crucial information. Tactics that help you improve door-to-treatment-space time are 1) expedited triage with mini-registration process and 2) “pull until full” or “immediate bedding” processes. Aim for an arrival-to-treatment-space time of 15 minutes or less.

EMERGENCY DEPARTMENT PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE (APRN)/PHYSICIAN ASSISTANT (PA) CONTACT
The time of first contact of the physician, APRN, or PA (defined as an institutionally credentialed provider) with the patient to initiate the medical screening exam.
**STUDER GROUP TIP:** It’s crucial to have a process to document this time as it’s considered the start of the medical screening exam (MSE). Ideally, arrival-to-provider-contact time is 30 minutes, and treatment-space-to-provider-contact time is 15 minutes or less. To ensure accountability, set leader evaluation goals based on both of these times.

**EMERGENCY DEPARTMENT DOCUMENTATION OF DISPOSITION TO DISCHARGE**
The time that the ED physician/APRN/PA completes a documented decision to discharge the patient*.

*“Documented decision to discharge the patient” is when the medical screening exam and all treatments and interventions are completed, the diagnostic results reviewed, and the patient is ready for discharge.

**STUDER GROUP TIP:** Again, be sure this time is clearly documented in the emergency department medical record. To improve this metric, implement standardized triage protocols when all emergency department beds are full to expedite care, and set service agreements for turnaround times (TATs) with ancillary partners such as lab and radiology. In addition, implement a process to assist physicians to screen test results as soon as returned.

It’s critical to keep patients informed during this process. AIDET™ and Hourly Rounding are two tactics that can help. See tactics section, pg 4, for more information.

Once patients have a discharge order, the goal is to have them discharged within 15 minutes. Consider using nurse expeditors in this role to improve this metric.

**EMERGENCY DEPARTMENT DECISION TO ADMIT**
The time that the ED physician/APRN/PA documents a decision to admit the patient*.

*“Documents a decision to admit the patient” is when the medical screening exam has been completed and stabilizing treatments and interventions have been initiated, diagnostic results needed for admission have been reviewed, and the physician is ready (per hospital process) to initiate the admission process.

At the current time, the ED Metrics Stakeholders believe that this time stamp is variable and should be defined and made consistent through all institutions.

**STUDER GROUP TIP:** It is crucial for the physician to do a formal “open and close” with the patient using AIDET/Key Words to keep them informed. For example: “Mr. Thomas, as we discussed earlier, you have pneumonia in your right lung, and we will be admitting you to the hospital for approximately two to three days to continue your IV antibiotics and your breathing treatments. Dr. Graham will be overseeing your care and will be in to see you in the next hour. We have ordered you a bed and expect that you will go to the medical unit in the next two hours. Jan, your nurse, will be back to check on you in the next 30 minutes. What questions do you have for me? Is there anything else I can do before I go? Thanks for being so patient today and I hope you feel better very soon.”

Emergency department leaders should round on all patients who are to be admitted to provide a time line for admission and answer questions. Status should also be reviewed during bedside report at change of shift.

**ADMISSION TIME**
The time that the admission order is documented.

**STUDER GROUP TIP:** Clearly document this time stamp in the emergency department medical record. Aim for having the patient assigned to an inpatient bed within one hour of admission time. The best strategies for achieving this are no-delay nurse reports and emergency department forecasting at daily bed flow meetings. It is important to have an emergency department/inpatient collaboration team to work together to implement these best practices.

**EMERGENCY DEPARTMENT DEPARTURE TIME**
The time of physical departure of a patient from the ED treatment space. The time most closely represented by being out of the department and no longer the ED’s responsibility.

**STUDER GROUP TIP:** Track by unit the time that elapses between emergency department admission and the time of arrival on the inpatient floor. Review this data in monthly leadership meetings. Appropriate evaluations goals should be shared with emergency department and inpatient leaders.
DEFINITIONS—TIME INTERVALS

EMERGENCY DEPARTMENT LENGTH OF STAY
ED arrival time to ED departure time.

STUDER GROUP TIP: This is the total turnaround time for the emergency department patient and includes many of the segment intervals above. By implementing the Studer Group evidence-based Must Have® tactics such as Aligned Goals, Rounding for Outcomes, AIDET™, Key Words at Key Times, Expedited Triage, and Immediate Bedding, your emergency department will reduce overall length of stay and increase patient perception of care. Clear goals and staff expectations will create needed urgency to improve. It is imperative that leaders are trained to recognize staff who are doing well, coach those who need improvement, and counsel those who are not meeting expected performance. Validation is key to providing objective feedback in a timely manner and is best accomplished through direct observation of staff and Leader Rounding on Patients.

ADMITTED EMERGENCY DEPARTMENT PATIENT
The duration of time a patient remains in the emergency department after the decision to admit the patient to the facility has occurred, but before the patient has been transferred to an inpatient unit.

STUDER GROUP TIP: The upcoming Centers for Medicare & Medicaid Services (CMS) reportable measure is median time from emergency department admission to arrival on inpatient unit. High-performing emergency departments are creating cross-functional work groups now with their inpatient and ancillary leaders to implement best practices such as no-delay nurse report to streamline this process. The long-term goal is to get to 60 minutes or less, 90 percent of the time.

EMERGENCY DEPARTMENT OFFLOAD INTERVAL
Time of arrival to time of transfer of the patient from the EMS stretcher to the ED treatment space, with assumption of care by ED staff.

STUDER GROUP TIP: Consider using an electronic or manual tracking board at the ambulance entrance that lets prehospital personnel know which room patients are going to.