

PULSE REPORT

2010

*Emergency
Department*

Patient Perspectives on
American Health Care

PRESS  GANEY[®]

Executive Summary

Despite a prolonged economic downturn and a continued decline in capacity, patient satisfaction with U.S. hospital emergency departments stayed about the same in 2009, following a five-year upward trend. At least among the evaluations of 1.5 million patients treated at 1,893 hospitals that are the source for this report, hospitals have managed to overcome rising demand and overcrowding to avoid a drop-off in perceptions of ED care.

The challenges faced by hospitals in providing emergency care are intense. According to data from the American Hospital Association (AHA) and the National Center for Health Statistics, from 1990 to 2008 the number of annual emergency department visits in the U.S. rose from 90 million to 123 million, amounting to about 41 visits per 100 people. The number of hospitals operating EDs in the United States declined from more than 5,000 in 1991 to fewer than 4,000 in 2006. In March 2010, an AHA survey found that 17% of EDs at reporting hospitals were “over capacity” at some point in that month while 21% were “at capacity.” Twenty-two percent of hospitals reported periods of time in which they diverted ambulances to other facilities as a result of capacity problems.

In that climate, the relatively high marks patients give EDs strongly suggest that hospitals continue to work hard to improve the quality of care they provide. In this report, three hospitals that have embarked on ambitious efforts to optimize patient throughput and improve communication and customer service are profiled.

The priorities for improvement identified by patients in 2009 were the same as in 2008, led by keeping them informed about delays in care, controlling their pain and the degree to which staff members cared about patients personally. Only one priority moved up, and that was pain control (to second). In general, the priorities continue to suggest that how well patients are treated as human beings is more important than the quality of the facilities and equipment in the ED.

The average time spent in the ED increased by four minutes in 2009 to four hours and seven minutes, following a decrease of two minutes in 2008. One state, Utah, saw its average time skyrocket in 2009. The state had the highest ED wait times in both 2008 and 2009, but the average time rose by 89 minutes to eight hours and 17 minutes — two hours and 34 minutes longer than the next worst state, Kansas. In stark contrast, Nevada patients spent 66 fewer minutes in the ED in 2009 than in 2008, and its ranking on the index rose to 37th from 43rd. Iowa had the shortest ED times at 175 minutes on average.

As in prior years, it appears that patients are willing to wait for care as long as they are kept informed about the wait time. Patients who reported that they received “good” or “very good” information about delays reported nearly the same overall satisfaction whether they had spent over four hours or less than one hour in the ED.

Among metro areas, patient satisfaction with ED care was highest last year in Madison, Wis., which failed to make the top metro area list in 2008. Miami-Fort Lauderdale-Pompano Beach, Fla., which was No. 1 in patient satisfaction in 2008, fell to sixth last year, but 2009 marked the third consecutive year it made the list.

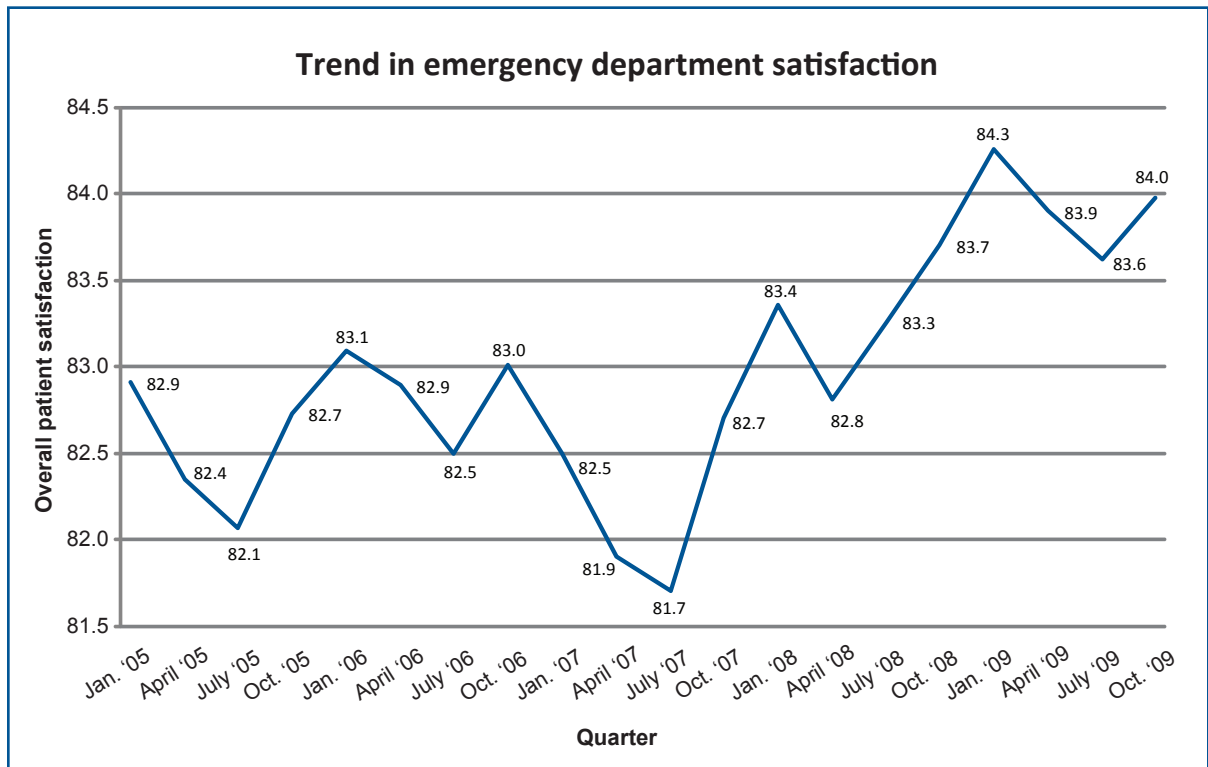
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The Status of Emergency Department Satisfaction

Five-year Trend in Emergency Department Patient Satisfaction

Patient satisfaction with visits to the ED has increased overall for nearly five years. However, since October 2008, it has remained relatively stable at around 84. Prior to this, satisfaction climbed steadily since July 2007, with the exception of one dip in April 2008. Thus, one year ago it appeared that this country's emergency care was robust despite the challenges of the current recession. As Press Ganey experts have seen, it seems the loss of jobs, loss of insurance and ED overcrowding resulting from the recession has finally taken its toll. Keep in mind that there is a cyclical pattern year-to-year where satisfaction dips in the spring months, possibly a carry-over from the crowded EDs during the beginning of the year.



National Priorities for *the Emergency Department*

Year after year, the priorities for improvement have remained relatively stable. All of 2009's priorities for improvement were also priorities in 2008, and all but the fourth item were priorities in 2007. This indicates that more work must be done to make progress on these low-scoring issues that are crucial to patient satisfaction. Reducing or eliminating delays in emergency care would certainly help to improve patient satisfaction, but Press Ganey data show that keeping patients informed about delays and setting expectations appropriately can also have a strong mitigating effect. It is interesting to note that for the past two years, "How well was your pain controlled" was the third priority, and this year it is the second. It may be that patients are becoming more sensitive to this issue, or that pain control efforts have slipped in the past year. Regardless, this issue deserves greater attention. In general, the priorities all point to the need for more humanistic than logistic improvements in emergency care.

National emergency department priority index

Survey item	Mean	Correlation	Priority Rank
How well you were kept informed about delays.	71.3	0.726	1
How well was your pain controlled.	77.9	0.722	2
Degree to which staff cared about you as a person.	82.0	0.795	3
Overall rating of care received during your visit.	83.0	0.897	4
Nurses' concern to keep you informed about your treatment.	83.1	0.702	5

Survey Items are correlated to patient ratings of "Likelihood of your Recommending this Hospital to others."
Represents the experiences of 1,501,672 patients treated at 1,893 hospitals nationwide between Jan. 1 and Dec. 31, 2009.

Metro Areas

with the Highest Emergency Department Satisfaction

Patient experiences can vary based on many factors, including where patients receive care. The following table identifies metropolitan areas with the highest levels of ED patient satisfaction. Regions with the highest mean scores are setting a new standard for excellence. Remaining competitive requires a concentrated focus on meeting patient needs and expectations.

This is the third consecutive year that Miami appeared on this top 10 list.

Top metropolitan areas – emergency department

Rank	Area	Overall Mean Score
1.	Madison, Wis.	86.9
2.	Grand Rapids, Mich.	86.1
3.	Hartford, Conn.	86.0
	Indianapolis, Ind.	86.0
	New Orleans, La.	86.0
6.	Miami-Ft. Lauderdale, Fla.	85.8
	Milwaukee, Wis.	85.8
8.	Toledo, Ohio	85.6
9.	Allentown-Bethlehem, Pa.	85.5
10.	Albany, N.Y.	85.4

Represents the experiences of 1,399,047 patients treated at 1,725 hospitals nationwide between January 1 and December 31, 2008

Time Spent in the Emergency Department by State

In 2009, patients spent an average of four hours and seven minutes in the ED, an increase of four minutes since 2008. Although this is an increase, it must be considered in the context of economic challenges faced during the year. Even in the face of overcrowding and budget constraints, 32 states have either reduced wait times or held increases to five minutes or less. This is a testament to the hospitals' efforts to improve quality. One state showed particularly notable improvement – Nevada patients spent an average of 66 fewer minutes in the ED in 2009 (262 minutes) than in 2008 (328 minutes). Utah patients, on the other hand, averaged 89 minutes more in the ED than they had just a year before.*

Average number of minutes spent in U.S. emergency departments

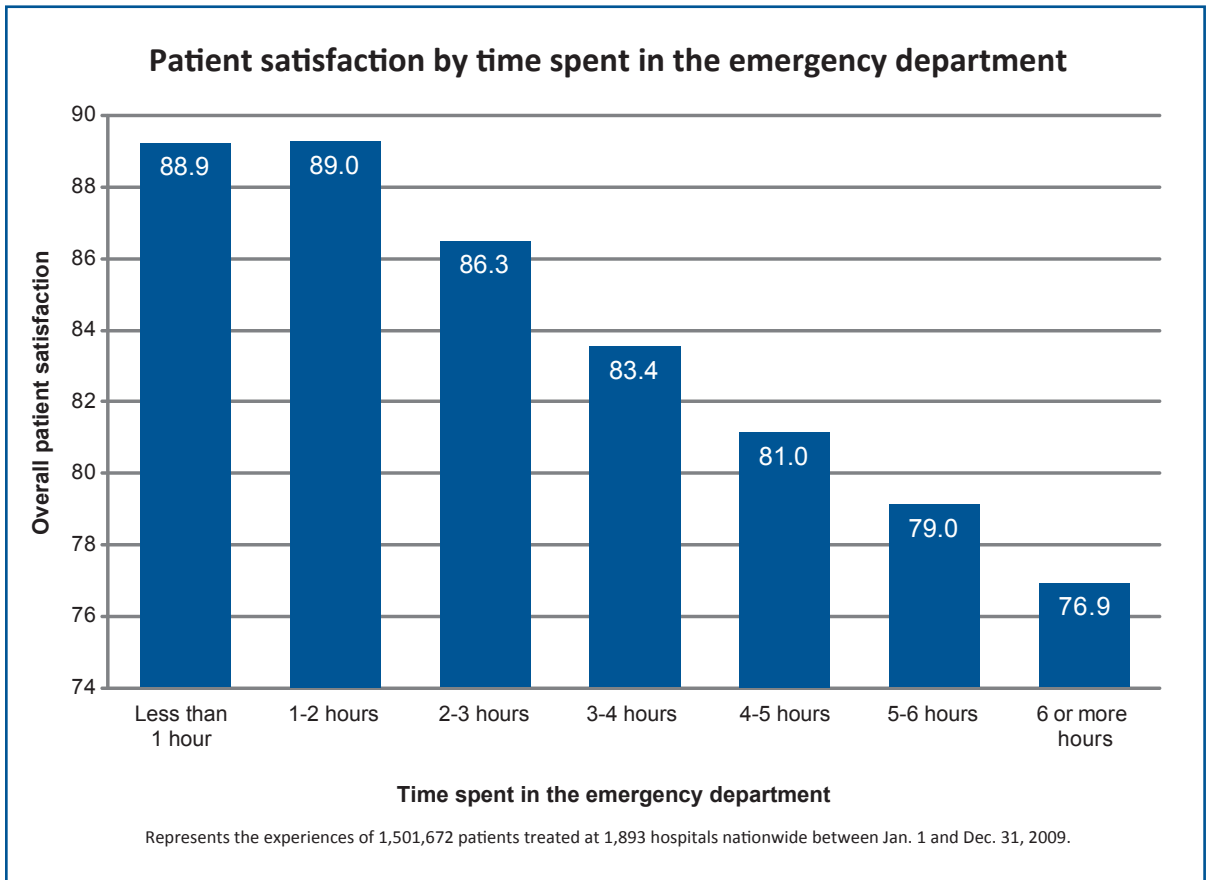
Rank	State	2009 Average Number of Minutes Waited	Change in Average No. of Minutes Waited from 2008 to 2009
1	Iowa	175	-7
2	South Dakota	179	7
3	North Dakota	187	1
4	Nebraska	188	7
5	Minnesota	191	1
6	Idaho	194	19
6	Montana	194	8
8	Wyoming	195	18
9	Wisconsin	197	1
10	Hawaii	204	-8
10	Maine	204	3
12	Vermont	207	5
13	Indiana	214	-5
14	West Virginia	215	13
15	Louisiana	225	-11
16	New Hampshire	227	23
16	Oregon	227	-12
18	Tennessee	228	6
19	Oklahoma	233	17
20	Arkansas	234	18
21	Missouri	236	3
22	Pennsylvania	237	-2
23	Ohio	239	3
24	Colorado	241	-1
25	Illinois	241	-8
26	Massachusetts	244	-4
26	New Jersey	244	-3
26	Texas	244	-14
29	Connecticut	247	0
30	Alabama	248	0
30	Michigan	248	-8
32	Georgia	249	-11
32	Kentucky	249	5
34	Washington	250	0
35	Alaska	256	6
35	North Carolina	256	-5
37	Nevada	262	-66
37	Virginia	262	-1
39	Florida	264	3
40	California	274	2
40	South Carolina	274	0
42	Delaware	275	33
43	Rhode Island	284	3
44	New Mexico	285	-8
45	Maryland	292	30
46	Mississippi	296	41
46	New York	296	18
48	Arizona	329	19
49	Kansas	343	21
50	Utah	497	89

* According to the American College of Emergency Physicians web site (<http://www.emreportcard.org/Utah.aspx>), it is suggested that residents of Utah have very poor access to care. The site also reports high rates of uninsured children and adults, as well as a relatively low percentage of adults insured through Medicaid. Thus, one reason for Utah's ranking could be due to a high rate of uninsured gaining access for routine care through the ED. Utah also has the second lowest rate of staffed inpatient beds in the nation (210.2 per 100,000 people), and has the fifth lowest rate of registered nurses currently in the workforce (646.2 per 100,000). This could create a backlog of patients in the ED. All of these factors could contribute to driving up the amount of time spent in the ED in Utah.

Patient Satisfaction

by Time Spent in the Emergency Department

Patients who spend more than two hours in the ED report less overall satisfaction with their visits than those who are there less than two hours. Since much of the time in the ED is spent waiting — in the waiting room, in the exam area, for tests, for discharge — reducing wait times should have a direct positive impact on patient satisfaction. The best way to get patients treated and discharged from the ED is to address overcrowding in general and get the critical patients through the ED and to the appropriate floor faster. This frees up resources for the less-critical patients to be cared for and discharged from the ED.



Actual Time versus Perceived Time

Spent in the Emergency Department

Press Ganey bases the wait times described in its Pulse Reports on patients' self-report of the total time they spent in the ED. Press Ganey researchers recently conducted a case study of the differences between patient self-reports of time spent in the ED and actual time spent in the ED.

Moses-Taylor Hospital, in Scranton, Pa., measured actual time in the ED using a patient-tracking system. Press Ganey researchers conducted analyses on the Moses-Taylor data collected between January and December of 2009. They found strong correlations between self-reported time spent and actual time spent, indicating that patients are quite accurate in their reports of time spent in the ED. On average, patients slightly overestimate the time they spend by approximately 20 minutes.

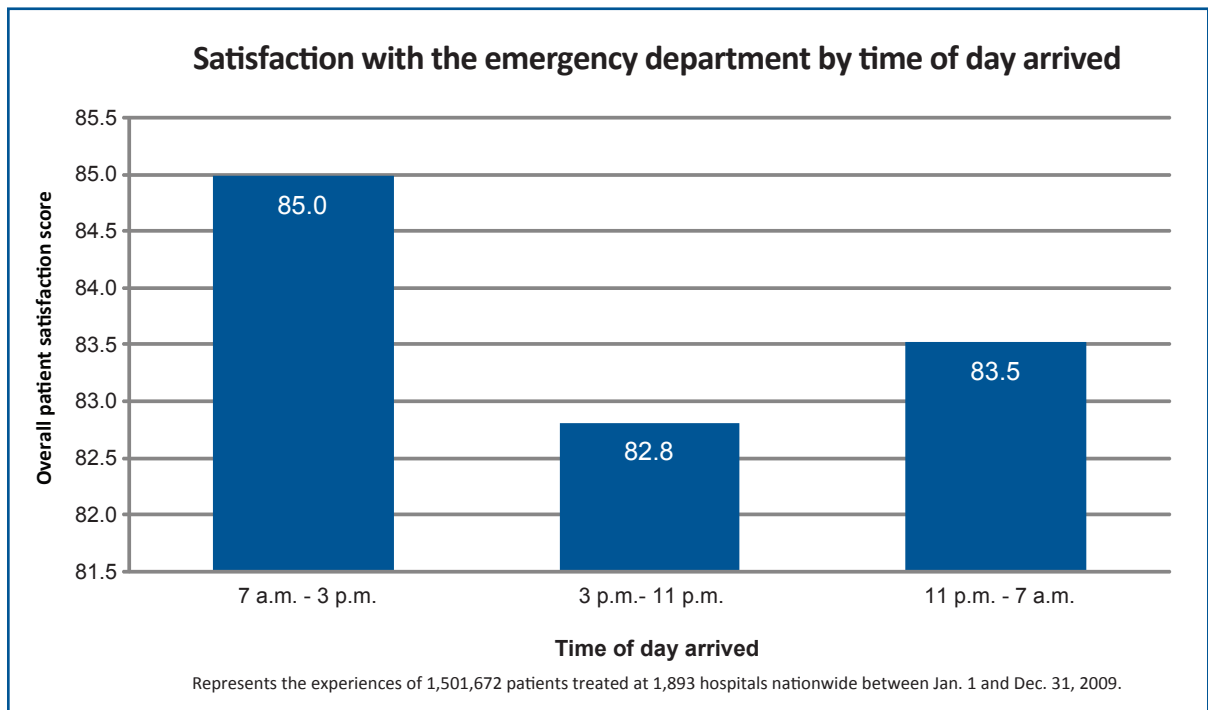
Future research will focus on differences between the types of patients who tend to overestimate their time spent in the ED and those who tend to underestimate their time spent. Analyses will investigate whether these tendencies are a result of the type of care the patient experiences or the level of expectation the patient brings to the care environment.

It is important to understand the differences between patient reports of time spent and actual time spent to promote a better understanding of patient perceptions and ultimately enhance their satisfaction. Obviously, reducing actual time in the ED is important, but the patients' perceptions of time spent in the ED are equally important.

Patient Satisfaction

by Time of Day Arrived in the Emergency Department

Patients who arrive in the emergency department between 7 a.m. and 3 p.m. report higher satisfaction than those who arrive in the evening or overnight hours. Staffing patterns, patient volume, and acuity of patient conditions may play a large part in these differences in satisfaction. By mid-afternoon, wait times may be on the rise as patient volumes have increased during the day. If a shift change is occurring during a particularly busy time, it may add to any actual or perceived disorganization or delays for patients.



To help address this issue, there are several things hospitals can do, including:

- Ensure there is adequate staffing during the busiest part of the day.
- Expedite patients early in the day so that there are open beds to accommodate patients in the busy afternoon and evening hours.
- During shift changes, have nurses do bedside transitions with the exiting nurse introducing the incoming nurse to the patient, family, etc.

While it's beneficial to address delays and provide information, ultimately, the reason behind the delays needs to be investigated and addressed.

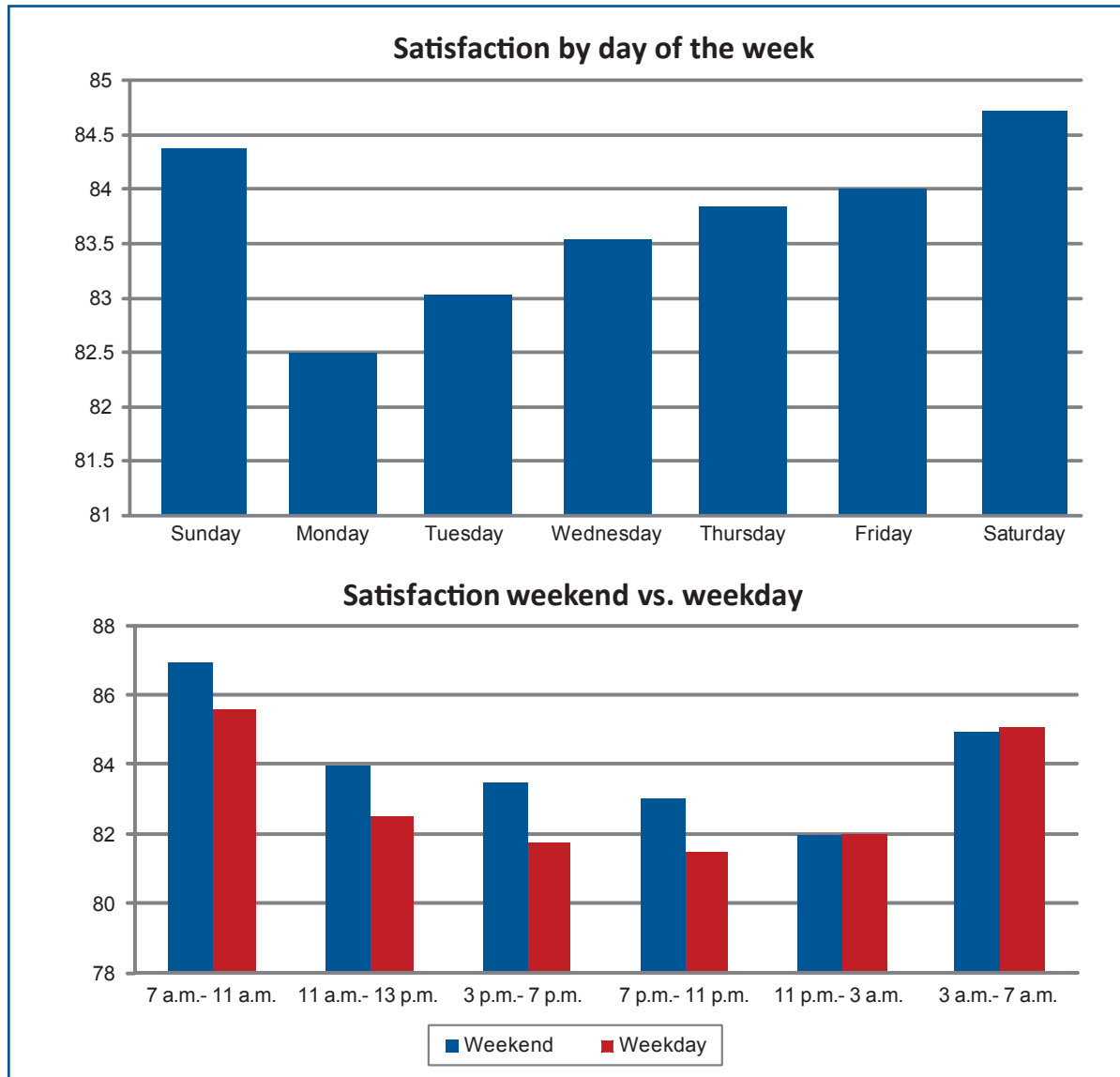
Patient Satisfaction

by Day of the Week and Weekend versus Weekday

The first graph clearly shows that Monday has the lowest overall mean score for patient satisfaction with the average mean score rising steadily before reaching its pinnacle during the weekend.

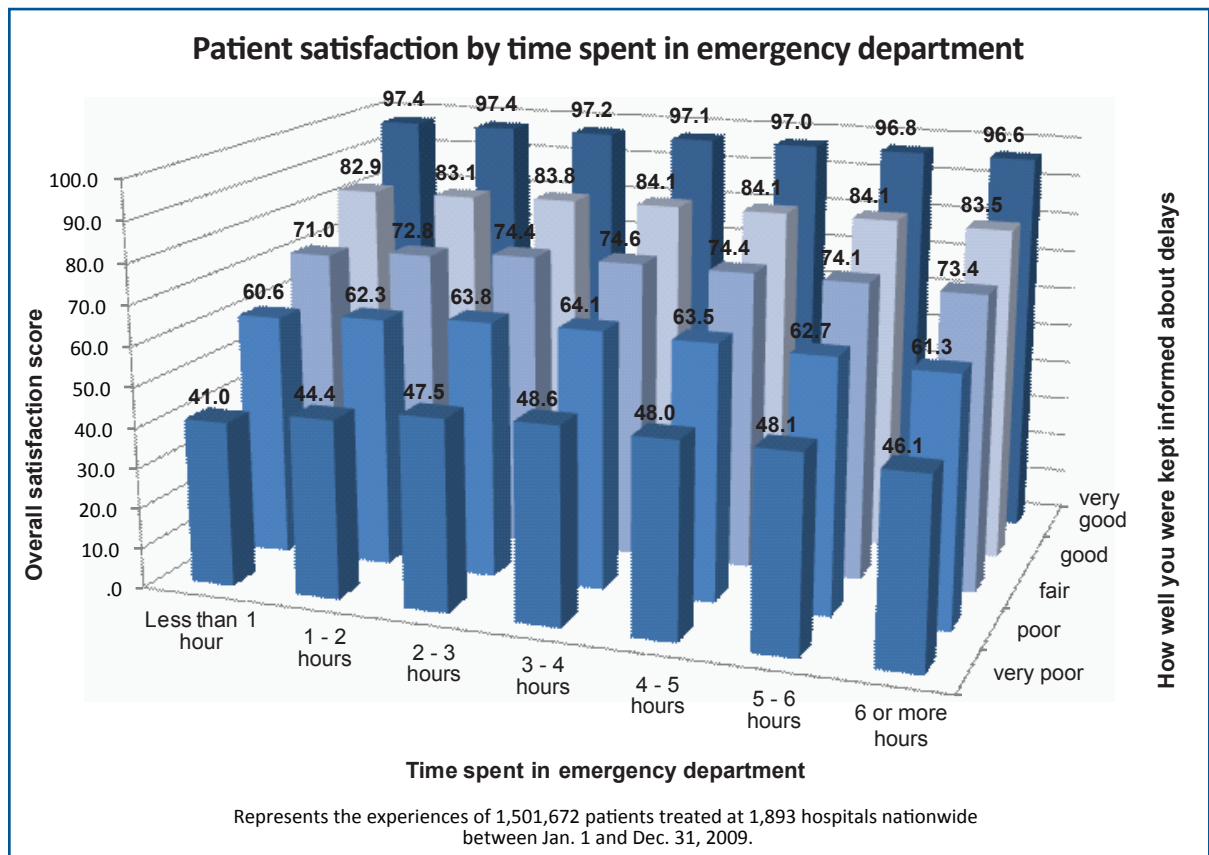
The second graph drills deeper into this data by dividing scores into weekend versus weekday, as well as into six time periods throughout the day. Scores indicate that satisfaction is highest during the 7 a.m.-11 a.m. time period for both weekend and weekday. After 11 a.m., both weekend and weekday scores decrease steadily through the 7 p.m.-11 p.m. period. At this point, the weekend scores decrease again for one more period, while the weekday scores increase slightly. From 11 p.m.-3 a.m. and 3 a.m.-7 a.m., both weekend and weekday scores increase sharply.

According to the Centers for Disease Control (<http://www.cdc.gov/nchs/data/nhsr/nhsr007.pdf>), in 62.9% of adult ED visits, the patient arrived after business hours. Despite this, Press Ganey consultants have noted that many organizations are staffed as if they were 9 a.m.-5 p.m., Monday through Friday operations. This could be one reason why weekdays between 3 p.m. and 3 a.m. are a weak spot.



Strategies for Improving Satisfaction with Wait Times

Although overall patient satisfaction declines for patients who have spent more than two hours in the ED, hospitals that cannot eliminate long waits can give satisfaction a considerable boost by keeping patients informed about delays. Patients who reported that they received “good” or “very good” information about delays reported nearly the same overall satisfaction whether they had spent over four hours or less than one hour in the ED. Similarly, those who reported “very poor” communication about delays, but spent less than one hour in the ED, reported lower overall satisfaction than those who had been there for over four hours but had been better informed about delays. The lesson for hospitals is that communication about wait time in the ED is nearly as important as the actual wait time. Patients need to feel included and important.



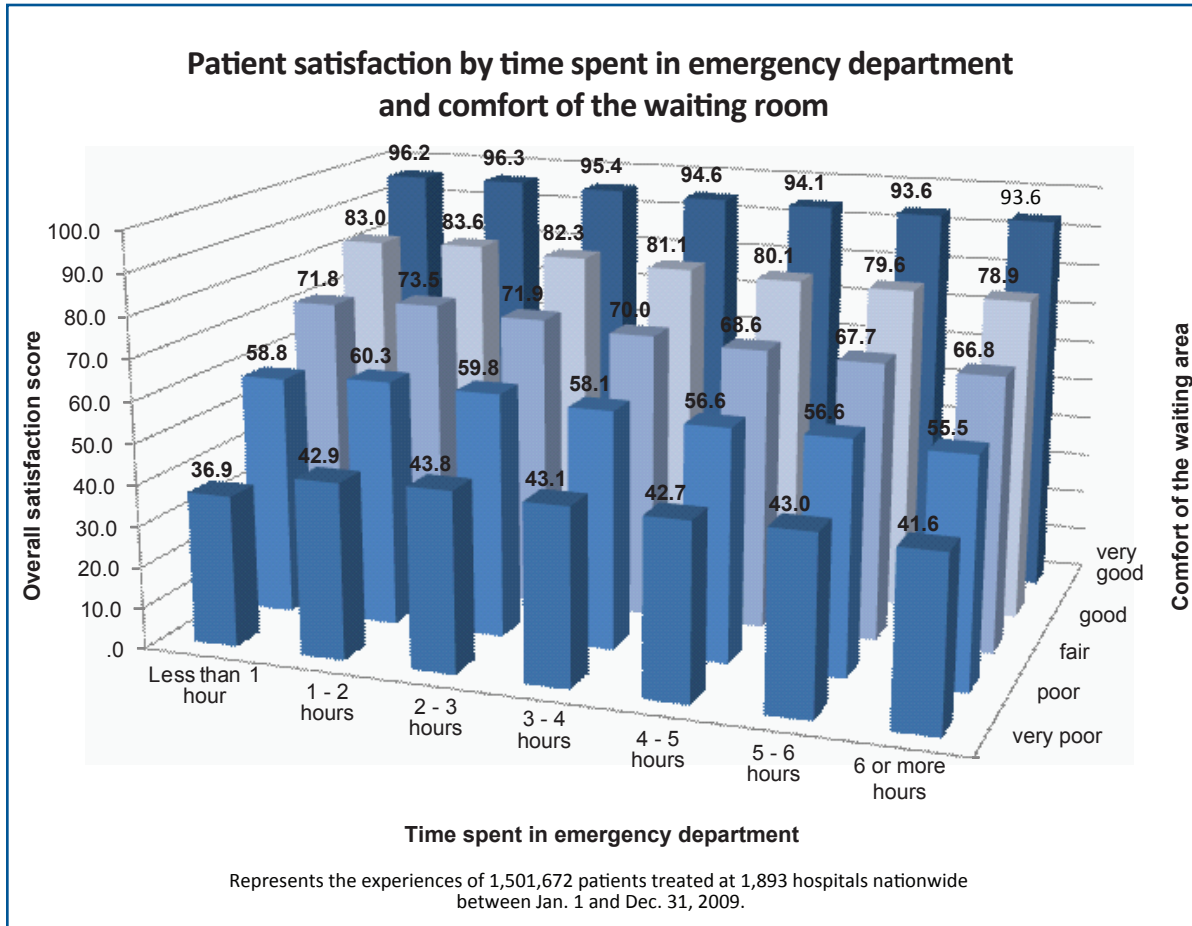
To communicate with patients in the ED, many hospitals have white boards in the exam rooms to keep patients informed about their treatment and delays. Also, a welcome letter or pamphlet for the patient describing the process in the ED can help set expectations. For example, “After check-in, you will sit in the waiting area until called for your initial assessment/triage, etc.”

For more examples of “what to expect” in the ED, visit www.improvemyer.com.

Patient Satisfaction

by Time Spent in the Emergency Department and Comfort of the Waiting Room

In addition to good communication about delays, EDs that cannot reduce wait times can recover some patient satisfaction by improving the comfort of their waiting rooms. Whether patients spent one hour or four hours in the ED, those who rated the waiting room as “very poor” in comfort had dramatically lower overall satisfaction with their visit than those who rated the comfort of the waiting room as “very good.” Hospitals can analyze their patients’ comments to find ways to improve the comfort level. Changes such as repairing the air conditioning or replacing the chairs may have a noticeable effect on patients’ perception of the ED.



Strategies for Reducing Waiting Time *in the Emergency Department*

Wait time in the ED is not always indicative of problems in the ED. More often, it is an organizational issue that keeps the patients in the ED when inpatient beds are not readily available. A 2009 study on ED utilization and capacity by the Robert Wood Johnson Foundation found that ED overcrowding is caused by a complex set of conditions that occur across hospital units and across the entire health care system. Inability to move admitted patients from the ED to the appropriate inpatient unit stands out as a major driver of ED overcrowding.

According to the National Center for Health Statistics (NCHS), a division of the Centers for Disease Control and Prevention (CDC), while the number of EDs across the country has decreased, the number of ED visits has increased. As a result, EDs are experiencing higher patient volume and overcrowding, and patients seeking care are experiencing longer wait times. The CDC also found that the ED was the portal of admission for 50.2% of all non-obstetric admissions in the United States in 2006, an increase from 36.0% in 1996.

In addition, while overall outcomes are not changed, patients who board (patients who don't have beds, but rather use beds in the hallways) in the ED have longer lengths of stay than those who don't. Hospitals have been able to achieve better satisfaction and reduction in waiting time and length of stay when improving flow from the ED to the inpatient bed.

Unclogging the ED by Fixing the OR

WellStar Kennestone Hospital smoothes out elective surgeries to ease patient flow throughout the facility

Vital Statistics

The emergency department at WellStar Kennestone Hospital in Marietta, Ga., a 572-bed facility in suburban Atlanta, averages 103,000 visits each year, impressive numbers given that it is not a trauma center. The general medical-surgical hospital had 34,346 inpatient admissions last year. Its physicians performed 9,590 inpatient and 12,706 outpatient surgeries.

The Bottom Line

Faced with backups in its emergency department in 2007, WellStar Kennestone Hospital found that the issue was not a surge in ED volume, but an inability to get patients being admitted through the ED to inpatient units and competition in the operating suite between emergency cases and scheduled surgeries.

The hospital turned to Press Ganey's PatientFlow Optimization, which uses a variety of solutions — including the same queuing theory used to solve long waiting times in restaurants — to reduce variability in scheduled surgeries for operating rooms.

The new queuing method allowed urgent surgical cases admitted from the ED to move directly into designated emergent/urgent ORs. The result? Wait times for patients requiring surgery within four hours dropped by 78%, and there was an average wait time decrease of 21% for urgent surgical patients across the board, which meant fewer patients in the ED. The mean score for overall satisfaction with the ED experience rose from 78.2 before the first phase of the project to 80.9 after implementation. Elective surgery volumes increased by 10% in one year. WellStar Kennestone is able to see more patients in the same amount of time because it no longer has to worry about bumping scheduled surgeries for urgent cases. In only eight months, waiting times for urgent cases in the cardiac catheterization lab decreased 75% from an average of 25 hours to just six.

The Back Story

On March 15, 2007 WellStar Kennestone Hospital experienced an unprecedented logjam in its ED. The backup was traced not to a surge in volume but to an inability to get patients being admitted through the ED to inpatient units and to competition in the operating suite between emergency cases and scheduled surgeries. As a result, ED beds began to fill up, patients waited an average of nearly 19 hours to be admitted, a record 50 ED patients left without being seen and ED patients who could go home waited nearly eight hours on average before being discharged. As this *Pulse Report* indicates, those are the leading indicators of patient dissatisfaction with ED care.

ED overcrowding is often thought to be the cause of patient bottlenecks, with cascading effects in the rest of the hospital. The emerging science of patient flow management utilized by Press Ganey has found that ED wait times can be traced to variability in elective surgical case volume.

The situation that March day at WellStar Kennestone illustrates the delicate equilibrium of WellStar Kennestone's ED, operating rooms and floor units; but the inherent problems that caused the crisis in the ED were merely more severe on that day. Competing flows of patients and unmanaged case volumes were issues that had been occurring for years.

The long wait times were causing patient and employee stress levels to rise, compromising access to care, losing revenue for the hospital and damaging the hospital's reputation in the marketplace. The message patients sent WellStar Kennestone on their Press Ganey ED satisfaction surveys was clear: "We don't like to wait."

The fact that satisfaction declines considerably for every hour a patient spends in the ED was well-known at WellStar Kennestone long before that disastrous day in March, 2007, where wait times in the four- to six-hour range were the norm. “After looking at patient satisfaction data for two years, we realized nothing would change unless we really started focusing on providing better customer service and improving our processes,” said Stephanie Clark, director of Strategic and Quality Learning for parent WellStar Health System in Atlanta.

Looking at all aspects of the patient experience, WellStar Kennestone’s leaders launched initiatives to address wait times, patient throughput and boarding and the discharge process.

WellStar Kennestone contracted with PatientFlow Technology in July 2007 to help solve the underlying problems that were affecting its ED, ORs and nursing units. PatientFlow — acquired by Press Ganey in January 2009 — soon found that WellStar Kennestone’s ED bottlenecks were not actually caused by its large ED patient volumes, but were primarily the consequence of variability in elective surgical case volume and the competition between emergent/urgent cases and the elective schedule.

Hard and Soft Science

Using a data-driven, “hard-science” approach for real-time analysis of daily admissions, Press Ganey was able to show that the volume of WellStar Kennestone’s ED admissions was actually more predictable on a daily basis than elective surgeries throughout a given week. By setting aside separate OR capacity for the emergent and urgent cases, the variability in non-elective case volume can be managed, even though it can never be eliminated. In contrast, variability in the elective surgery schedule can be largely eliminated so that flow is smoothed, leading to an effective increase in capacity and decrease in overtime and stress. Collaboration between physician and hospital leadership added the “soft-science” approach of change management WellStar Kennestone needed to begin a three-phase strategy for improving patient flow.

Phase one began with comprehensive data collection and analysis of elective and non-elective surgical volumes. This allowed WellStar Kennestone’s staff members to shift their focus away from anecdotal evidence and begin an objective investigation of the causes of ED bottlenecks. Working closely with Press Ganey, WellStar Kennestone’s physicians used data from their own surgical cases to determine an urgency classification system for their add-on emergent and urgent cases. This system was used to prioritize which cases should get into the OR first, and to establish clinically based maximum wait times from when a case was booked and when surgery began.

To determine the capacity needed for emergent/urgent cases in the OR, PatientFlow applied a queuing model using WellStar Kennestone’s arrival patterns, average case duration and urgency classifications. “Queuing theory is a mathematical tool that has been used in industry for decades to help manage random arrivals. It works very well in hospitals to help calculate the capacity needed to handle randomly arriving emergent and urgent cases,” said Susan Madden, vice president of product analytics for Press Ganey.

With input from the physicians, the hospital designated operating rooms specifically to care for the emergent/urgent surgical volume.

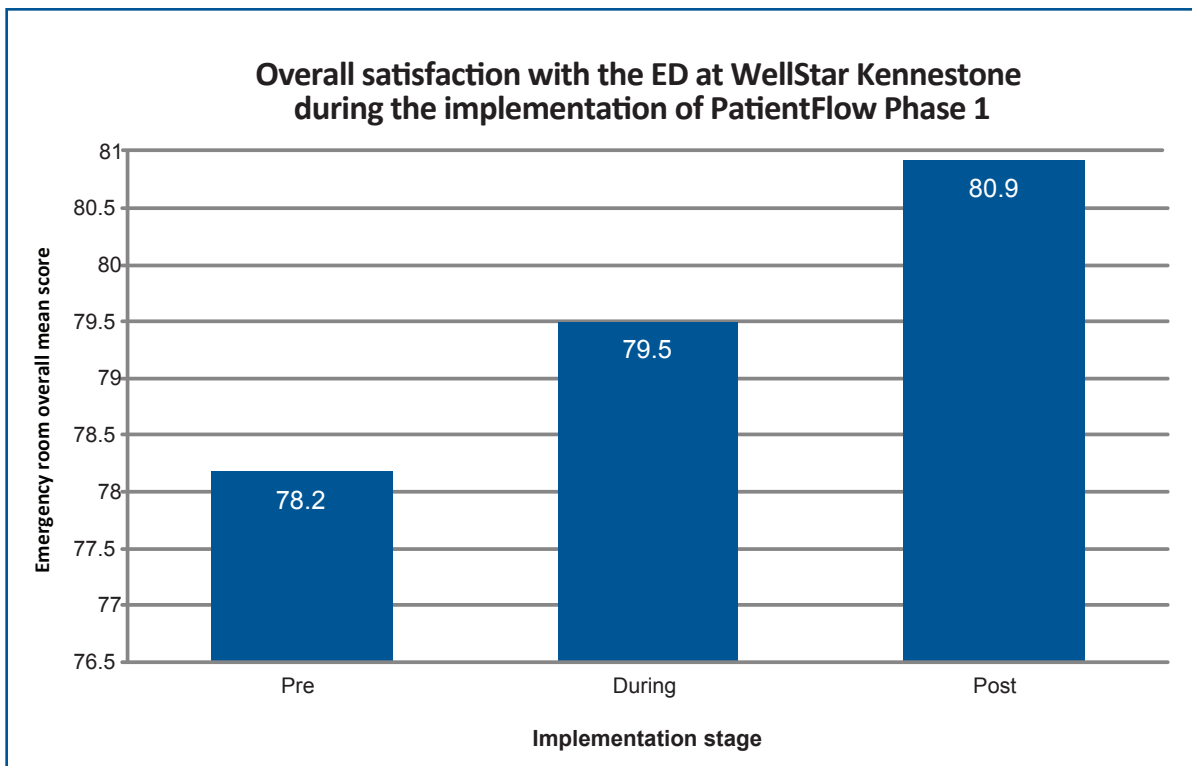
The second phase of the patient flow project uses surgeon-specific case data to smooth the elective surgical case schedule. The separate capacity for add-on cases eliminated competition between the two types of flows (add-on and scheduled elective). By separating flows, elective cases can be scheduled back to back, increasing utilization in the elective ORs. Although the average utilization rate in the add-on ORs is lower (usually 50% to 60%), the overall utilization of all ORs increases when the flows are separated. Press Ganey worked closely with surgeons to design a schedule where elective surgeries are smoothed throughout the week.

Smoothing is accomplished by examining the utilization of the OR by service and by surgeon, and also by understanding that postoperative patients need to be placed in the appropriate nursing unit after surgery. Press Ganey applied various scheduling scenarios in a simulation model that were evaluated by the hospital and physicians in order to find the best patient placement strategy to fit the hospital's needs. Some surgeons had to adjust their operating days and times, a difficult decision for the team, but one that resulted in better patient placement and a better schedule for physicians and staff.

"Physician and hospital leadership should be commended for their work during this difficult phase," says Christy Dempsey, senior vice president of operational and clinical consulting for Press Ganey. "By working together and making decisions based on data instead of anecdote, they were able to come up with a schedule that improved the lives of everyone — patients, physicians, staff and the hospital as a whole."

The third phase of PatientFlow Optimization also uses simulation models to determine proper bed and staff volumes that accommodate long-term strategic plans and growth. In this phase — which is still under way — WellStar Kennestone has begun to maximize throughput by streamlining the discharge process and addressing length-of-stay issues.

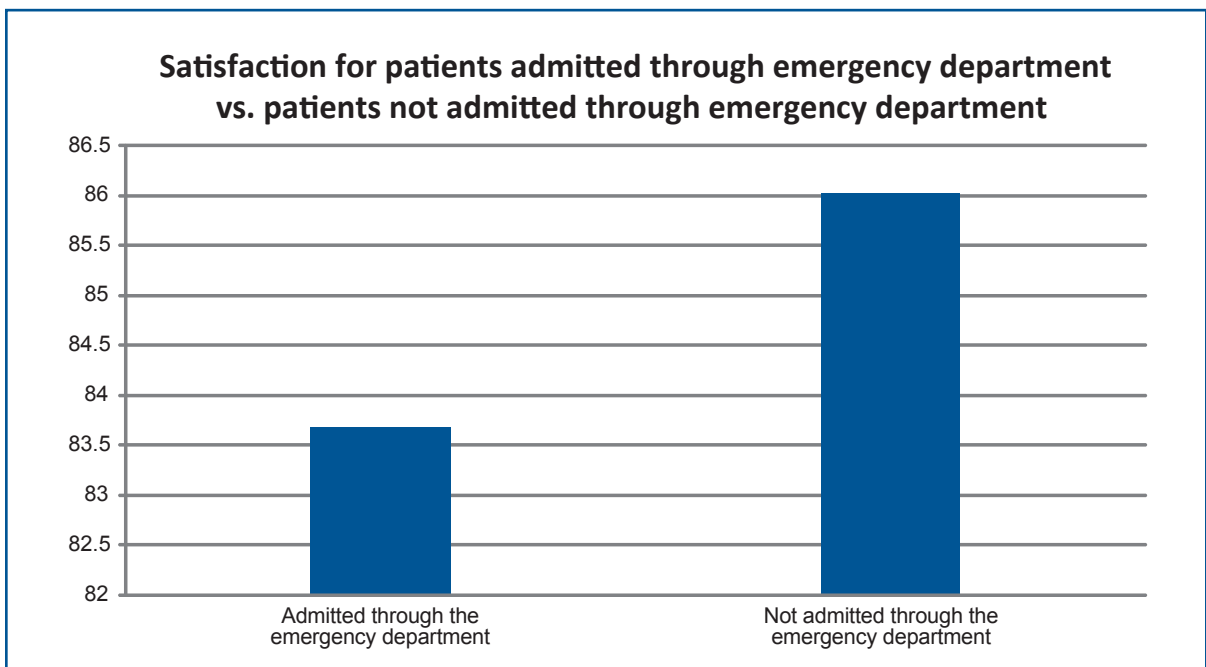
By partnering with Press Ganey, WellStar Kennestone Hospital was able to address flow issues throughout the organization that lead to better utilization and improved clinical quality, and was prepared to focus on improving patient satisfaction and efficiency in the ED.



Emergency Department versus *Non-Emergency Department Patient Admissions*

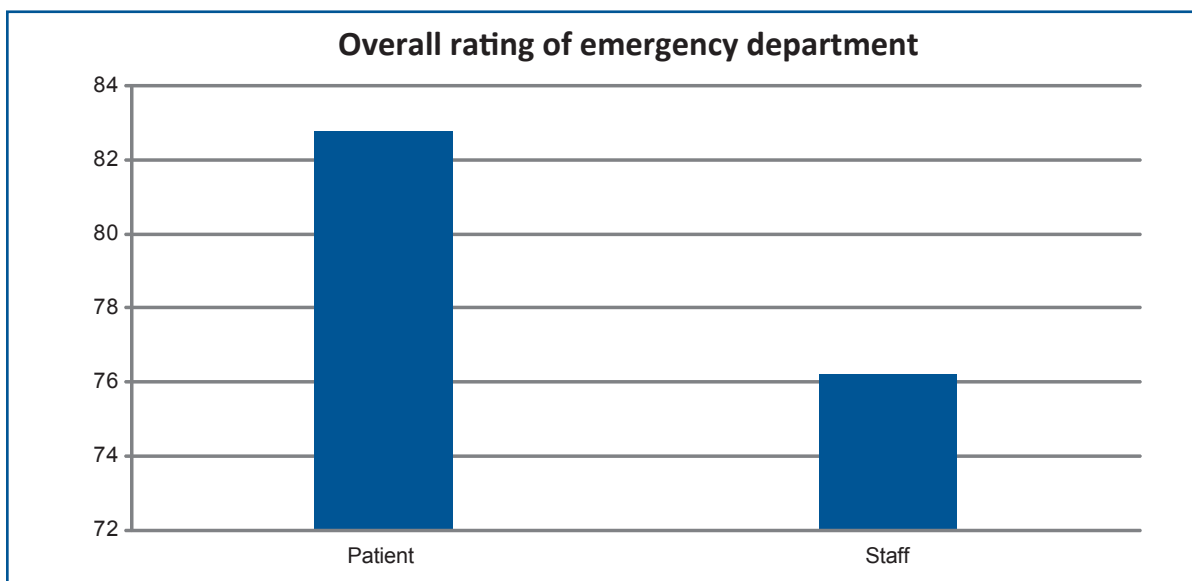
The graph below shows overall inpatient mean scores for patients admitted through the ED and patients who were not admitted through the ED. According to the data, patients admitted through the ED are less satisfied than those who were not.

This finding is intuitive if examined from the patients' perspective. For many ED patients, the health condition that resulted in their ED visit was unexpected, and, at a minimum, inconvenient. Add an unexpected admission to the hospital, and it's not surprising that this group of patients are likely to be sensitive to most details of their visit. This finding emphasizes the often stated adage that "the ED is the front door of the hospital." The fact that a patient's experience in the ED has such a robust impact on their inpatient satisfaction scores, and indirectly on CAHPS reimbursement, underscores the need for hospitals to take a closer look at the ED.



Staff Satisfaction *with the Emergency Department*

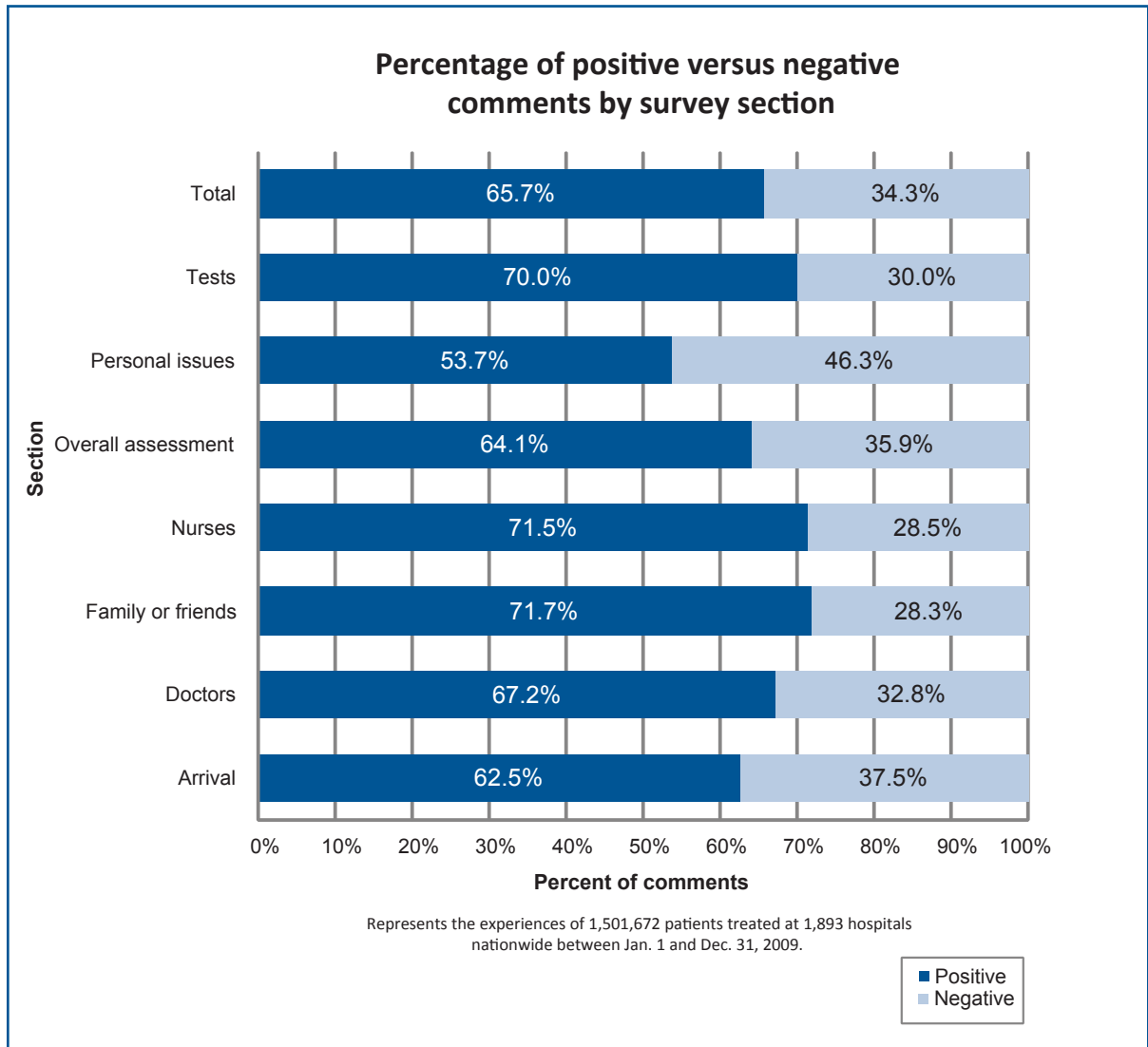
As shown in the graph below, staff members' overall rating of the ED is much lower than patients' overall rating of the ED. This may reflect the differences in expectations of these two populations. Obviously, each patient has a much more limited experience of the ED than staff. Each patient may only experience the ED once, whereas the staff experience it every day. With more experience and a focus on quality improvement, staff examine their ED with a critical eye.



Patient Comments Analysis

Positive vs. Negative

Comments on ED visits from over 1.5 million patients in 2009 were predominantly positive. In particular, more than two-thirds of comments about tests, nurses, doctors and treatment of family and friends were positive. However, almost half of the comments about personal issues were negative. A closer examination of comments in this area may help hospitals to understand the specifics of patient issues and to develop tailored initiatives to address them.



What Are Patients Saying?

POSITIVE

"The wait was excellent considering the amount of patients waiting for the test. The woman who took care of me while I was waiting was very friendly."

"They were extremely busy but managed to attend to all of the patients with great concern."

"They were kind enough to offer my nine-year-old daughter a sandwich since we were there for quite a while."

"Our experience was quite positive. Because the ER did not appear crowded, we moved through each step of the process very quickly. It was only a few minutes before my daughter received treatment."

"The best part was getting to the ER in under 10 minutes and not having to wait hours before being seen."

"Customer service is back — at least at your hospital!"

"I was treated courteously in a timely fashion and was always informed on treatment."

"I was quite surprised at how quickly and efficiently everything went."

"I don't have insurance, so I felt bad to be in there, but no one treated me like I was worthless."

"Nurses are the core of a hospital. Excellent!!"

"Staff was very kind to my boyfriend and mother and made sure they were comfortable."

NEGATIVE

"In the waiting room for over three hours before triage, with chest pain. Once I complained to the nurse manager, I was seen right away."

"Results of X-ray not given until several hours after X-ray taken and only when I asked the doctor."

"They made my friend leave and wouldn't give her updates. None of the staff was taking care of me, so it would have been nice to have my friend there."

"We waited over three hours to be acknowledged by the doctor — your staff just kept walking past my bed and never checked on my status!"

"They made me WAIT and STAY in the hallway for approximately five hours and told me I couldn't be moved to one of the spaces they had for patients. They called the hallway "Room 23C." Are you kidding me?"

"I felt unattended to. If I fainted, no one would have seen me for a while. I was alone in the room with terrible head/neck pain."

"I understand that there are other patients waiting, it is done by priority, but I would prefer the process to be faster."

"We waited close to two hours or more to be seen. This was due to the number of people there and time of night/possibly understaffed."

Welcome to the ED: I'll Be Your Concierge Today

At Staten Island University Hospital, administrators guide patients to their beds

Vital Statistics

Staten Island University Hospital, part of the North Shore-LIJ Health System, is a 704-bed, tertiary care, teaching hospital in New York City, located on two campuses. The hospital has numerous academic and clinical affiliations. The north campus operates as a Level 1 trauma center. The emergency department at the north campus — the subject of this case study — treated 75,000 patients in 2009, while the south campus ED treated 33,000 patients.

The Bottom Line

In June 2009, a four-year-old effort to improve patient satisfaction with the ED on the north campus had failed to deliver the desired results. The department was achieving solid clinical results, but scoring at the low end of the scale on patients' "likelihood to recommend" the facility as a good place to receive care. The staff was getting ready to move into a gleaming new 40,000-square-foot ED, but leaders feared that if they didn't act quickly, they would only be transferring old habits and processes to the new facility.

The solution was a revolutionary customer service program. At its heart is a new role called Administrator on Duty. Top managers of the ED serve as a sort of concierge, escorting patients shortly after arrival directly to the treatment area and monitoring the progress of care. Staff members were put through mandatory training on customer service excellence. New direct-to-bedside patient flow significantly decreased waiting times for care.

By the end of 2009, the ED had leaped to the 75th percentile nationally on "likelihood to recommend." The time from arrival to being seen by a doctor fell to 53 minutes in the first quarter of 2010 from 65 minutes in 2009. The percentage of patients who leave without being evaluated — a result of long waiting times — fell from 2.32% to 1.21%. That last statistic alone translates into nearly \$400,000 in additional annual revenue to the hospital. And all of this has been achieved in the face of a 13% increase in ED utilization.

The Back Story

Construction of a new emergency department at Staten Island University Hospital's north campus was a time of optimism for the hospital. "We were putting a lot of faith in our new space — that it would solve all the problems we were having with customer service," said Frank Morisano, RN, the ED's associate vice president. "Our old space was kind of dirty, overcrowded and unpleasant. What we soon realized was that unless we changed what we were doing, when we moved into the new space we would just be carrying forth all of our old habits."

Reviewing its Press Ganey Priority Index, Morisano and colleagues looked at low scores for patient satisfaction upon arrival, for waiting times to get to the treatment area and to see a doctor, for the likelihood of patients to recommend the facility and for overall rating of care; they knew major change was in order.

The first solution, which was implemented in the old ED, was called Boot Camp: every week leaders walked through the facility and wrote down where cleaning was needed and where equipment needed fixing or moving to make better use of space. They also followed up to ensure the issues were resolved in real-time.

The second was a mandatory two-hour class given to the entire staff in early March 2009. "We called it ACLS — Acute Customer Life Support," said Bartholomew Cambria, clinical operations manager and lead physician assistant in the ED. "We gave staff a tool kit of survival skills for dealing with patients in real time. We discussed the psychology of waiting and what we are doing to get patients to the room. We wanted intrinsic change rather than a short-term fix, and that is what set us apart from places that have seen their scores go up and then fall back again. We set a standard of accountability, and we have been holding our employees to that ever since."

It was a major cultural shift for nurses, physician assistants, physicians, ancillary staff and registrars, and it took some time to really take hold, Morisano says. “The work became not about us but about the patient’s needs. And I have got to be honest; our numbers show it took about a year before it was even partially embraced.”

“This year, however, our staff really is proactive,” said Cambria. “I hear them saying, ‘Hey, how come Peds 2 is empty and I see a patient in the waiting room.’ So their thinking and their culture has really changed, which got us to where we are today.”

In addition, leaders abandoned the old, linear model of patients arriving at the ED and being sent to the waiting room, then to a triage nurse, then to registration, then back to the waiting room and finally being sent to the treatment area (where the wait for a doctor continued). Patients now are moved directly to the treatment area, even if triage has to take place there.

The Concierge Is in the Building

The centerpiece of the customer service initiative is the Administrator on Duty program.

Each day from 10 a.m. to 3 p.m., one of a dozen ED administrators and managers will take a shift escorting patients directly to treatment areas. The process allows the administrator to provide real-time troubleshooting, noting where there are beds open or problems brewing. The program has been such a success that from 3 p.m. to 11 p.m. — peak census each day — a full-time “pavilion manager” now provides the same service.

“This is a very powerful tool, not only to help patients, but for effecting change right on the spot,” Cambria said. “You really get a great sense of how the staff works; they see your presence on the floor. And it just gives us a tremendous amount of information and allows us to get the buy-in for direct-to-room, for bedside registration and the other things that are important for us.”

Not only is the patient escorted to the room, but the family is now allowed to go to the treatment area with them. “We used to spend hours and hours every day arguing with family members about why they couldn’t see their loved one,” Morisano said. “I realized that if it was my son or my wife who was ill, I would sure want to be in there with them, so now we make that happen. It was a real change of culture and attitude for us.”

The ED leaders implemented Press Ganey Solutions Starters to help resolve problems such as nurses and physicians failing to take time to listen to patients and the people taking insurance information and performing medical tests not being courteous. “When you look at all of this, seriously, it’s the things your mother taught you when you were five years old,” Morisano said. “It’s really very grass roots what Press Ganey teaches us, but it refocuses us because sometimes we forget the basics.”

Once the new ED was up and running, leaders tracked Press Ganey data religiously and were surprised — unpleasantly — by one statistic. “We have a beautiful waiting room, but our scores were in the 6th percentile for satisfaction upon arrival,” Cambria said. “What we noticed was that the liaison who greets people was sometimes getting pulled out of the entry doing stuff that the concierge and the pavilion manager now do. So questions such as ‘How helpful was the person who greeted you?’ and ‘How long did it take for someone to notice you?’ were low. So we changed our practice and made sure the liaison was always at the desk unless a dire emergency arose. And even then, the concierge person always fills in.”

A year later, there is quite a different vibe in Staten Island’s ED. Said Morisano: “I was born and raised in this community, my family is here, and five years ago people would stop me to say, ‘Oh, man, I waited at Staten Island forever, and I am never going back there. Now it is, ‘Wow, what are you guys doing there? I was there last week, and everybody treated me like I was special.’ That is very fulfilling to me personally, to be viewed so differently today.”

After 'The Match,' a First Lesson

At Oregon Health & Science University, doctors are indoctrinated early to a culture of service excellence

Vital Statistics

Oregon Health & Science University (OHSU) in Portland, Ore., is Oregon's only academic medical center. OHSU operates two hospitals, the main OHSU Hospital and OHSU Doernbecher Children's Hospital, and numerous medical practice locations providing care for about 755,000 patient visits each year. As one of only two Level 1 trauma centers in the state of Oregon, OHSU provides emergency care for patients across the state and throughout the region; its four schools — medicine, nursing, dentistry and pharmacy — draw students from across the nation.

The Bottom Line

The 2007 arrival of John Ma, MD, as chairman of OHSU's Department of Emergency Medicine, marked a new emphasis on service excellence for both front-line staff and medical residents. All incoming residents now receive a letter discussing the role of service excellence in the ED, are trained on customer service principles their first day at the hospital and shadow a patient through the entirety of a single ED visit. By training residents, Ma hopes to spread best practices in service excellence to other institutions.

Other aspects of the OHSU ED's service improvement campaign include: a department-wide interdisciplinary service excellence committee, scripting at triage, follow-up phone calls to high-risk patients and others and doctors handing their business cards to patients in case they have questions following discharge. Despite a recent fall-off of scores that may be attributable to record ED volume and the aftermath of layoffs in the economic downturn, the overall trend for patient satisfaction at OHSU has been highly positive.

The Back Story

"At OHSU we have adopted a culture of 'always.' I promise that our department will always do what is necessary to provide you with a first-rate medical training and that you will graduate with all the necessary skills to practice as an outstanding emergency physician. One of the skills that will be strongly emphasized throughout your three years at OHSU is service excellence. The patient always comes first in the OHSU emergency department. Providing high quality and safe patient care is always our No. 1 priority. In the process, we always look to provide an outstanding experience for the patient and their family. The service excellence principles that you will learn will serve you well throughout your medical career."

— John Ma, MD, chairman of the Department of Emergency Medicine, OHSU Hospital

Those words are the first introduction of physicians-in-training to the OHSU Hospital emergency department. Ma sends them out in a welcome letter just after "The Match," the third Thursday in March each year when medical students are assigned to residency programs across the country. The letter has been so successful that other health systems have asked for copies of it.

"Dr. Ma wants to establish service expectations before residents even arrive," said Kim Bass, director of Service Excellence at OHSU Healthcare. "On their first day here, emergency medicine residents are also engaged in a lecture and discussion about customer service principles — including communication with patients and co-workers — all of which sets the tone for their educational experience at OHSU."

The emphasis on service doesn't end with orientation, though. Starting this July, new OHSU residents are required to follow one patient through the entirety of the patient's ED stay — from the moment they first arrive in the waiting room to the time they're ultimately discharged.

"If the patients are waiting three hours, so are the residents," Bass says. "Being on the other side of the care experience helps residents understand the long wait times and uncertainty that can sometimes characterize an ED visit, and that ability to empathize is just as important as learning medical skills."

These resident-focused efforts are just one component of a department-wide service improvement campaign started by Ma in 2007. When he arrived at OHSU, the ED's national percentile ranking for overall assessment of care was in the single digits. OHSU Hospital was beginning to focus on patient satisfaction across the organization, so Ma created his own service excellence group — co-chaired by a nurse and a physician, with interdisciplinary membership — just for the ED.

As a clinician and educator at an academic health center, Ma is also a big believer in data. Press Ganey monthly reports are shared with all faculty and residents and service excellence cases are presented at mortality and morbidity reviews. "The questions we're constantly asking ourselves," says Ma, "are 'What can we do differently next time? How can we make improvement continuous over time?'"

Review of the data have led the ED's service excellence group to implement a number of initiatives, including post-discharge follow-up phone calls to patients, scripting for conversations such as triage interviews, an ED expeditor program to keep patients up to date on delays and comment cards distributed at discharge.

Most of these changes may begin by addressing patient satisfaction, but end up touching on both clinical quality and employee engagement. Post-discharge phone calls, for instance, are made by an RN to all high-risk patients and at random to other patients.

"The calls address patient safety first: we want to make sure patients understand and are complying with their discharge instructions," Bass says, "but we also want to know if there were service opportunities we missed or individuals at OHSU whose excellent performance needs to be recognized."

Scripting for conversations, asking patients to fill out comment cards at discharge and having physicians and residents give out their business cards to patients are all efforts designed to address one of the most common issues in OHSU's Press Ganey Priority Index: "Response to concerns and complaints."

"Patient responses on that issue may not be about complaints," points out Bass, "it may just mean they had a question they were afraid to ask. Scripting — so we can consistently ask patients if they have questions — comment cards, and passing out our physicians' business cards are all ways to make sure that we're responding to concerns as they arise, and also recognizing outstanding service. "

Bass, who experienced OHSU's ED as a patient when she was in an auto accident, says she was pleased to see the results of the department's focus on service. "All of the things we've worked on as an organization, and the things Dr. Ma's focused on in the ED specifically, were on display," she says. "The ED physician introduced himself, explained the tests they were going to run, made it clear I could call him with any questions and thoroughly explained discharge instructions. I left the ED with the physician's business card, having completed a comment card and knowing exactly who to contact if I had questions — it was the kind of care that made me really proud to be part of OHSU."

Methodology

Press Ganey's Emergency Department Survey gives patients who have been treated and released from emergency departments the opportunity to provide feedback about their stay. The survey is used by emergency departments across the United States to improve the quality of the service and care they deliver. Highly valid and reliable, Press Ganey's survey consists of 31 standard questions organized into eight sections: Arrival, Nurses, Doctors, Tests, Family or Friends, Personal/Insurance Information, Personal Issues and Overall Assessment. Data discussed in this report — including data on time spent in the ED — are patient-reported.

Survey Distribution

Surveys are sent to patients shortly after they visit the emergency department, while the experience is still fresh in their mind. Only patients who are discharged from the emergency department receive a questionnaire; those admitted to the hospital are not eligible for an emergency department survey. Upon receipt by Press Ganey, completed surveys are processed and added to a national database. Press Ganey complies with the Health Insurance Portability and Accountability Act (HIPAA), which establishes national standards for the security and privacy of health data.

Definition and Calculation of Mean Score

Surveys received by Press Ganey are processed and added to the client's electronic data storage area. Processing takes place immediately to provide clients with up-to-the-minute information about their service quality. Responses to survey questions are converted to a series of 100-point maximum scales so that clients can compare different aspects of their performance on a common yardstick. First, for each person who took the survey, responses to the survey questions are transformed from a five-point scale to the 100-point scale. Items rated "Very Good" are awarded 100 points; those rated "Good," 75 points; items rated "Fair," 50 points, "Poor," 25 points and any items rated "Very Poor" are awarded zero points. Next, each respondent's individual item scores within a survey section (see above) are averaged to become scores for each section. Finally, section scores are averaged to become that respondent's overall satisfaction score. The average of all respondents' overall satisfaction scores is called the client's overall mean score and is stored electronically and made available to the client.

Definition of Correlations

A correlation indicates how much a change in one variable (e.g., an item score) is associated with a concurrent systematic change in another variable (e.g., overall satisfaction). A correlation represents the strength and direction of the relationship between two variables numerically, expressed using a correlation coefficient (called r) which can range from -1.0 to +1.0. The greater the distance from zero, the stronger the relationship is between the two correlated items. A positive correlation coefficient indicates that as the value of one variable increases, the value of the other variable also increases. A negative correlation coefficient indicates that as the value of one variable increases, the value of the other variable decreases. It is important to recognize that when two variables are correlated it means that they are related to each other, but it does not necessarily mean that one variable causes the other.

Priority Index Calculation

The Priority Index is an ordered list of survey items that shows the areas needing the most improvement. Survey items on the Priority Index are arranged from the "first item to work on" to the "last item to work on." The Priority Index reflects service issues that clients are performing relatively poorly on that are important to their patients. It is calculated by looking at two aspects of each survey item's data: (1) its average score, and (2) how well it mirrors the respondent's overall satisfaction score, as determined above. Survey items that (1) have low average scores, indicating that the facility's quality for that aspect of its care is lacking relative to other care aspects, and (2) faithfully mirror the respondent's overall satisfaction score, will have high Priority Index scores.

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All data and findings represent surveys returned by patients to Press Ganey clients.

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