Quality and Productivity Commission

32nd Annual Productivity and Quality Awards Program

"Innovating for Impact"

2018 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: NURSE PRACTITIONER FAST TRACK PROGRAM IN THE ED

DATE OF IMPLEMENTATION/ADOPTION: 12/15/16
(Must have been fully implemented for a minimum of at least one year - on or before July 1, 2017)

PROJECT STATUS: X Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes X No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

After the Urgent Care Clinic stopped sharing triage, which is the process of evaluating and prioritizing a patient's condition, with the Emergency Department (ED) in August 2016, the ED had a large increase in lower acuity Emergency Severity Index (ESI) patients. The ESI is a five level (1 to 5) emergency triage algorithm where level 1 indicates the greatest urgency. To accommodate the influx of lower acuity patients, we developed a program to use one 8-bed pod in the ED to see patients more efficiently by Nurse Practitioners (NP). The area is staffed by 2 NPs for 12 hours daily who team with nursing to move patients more quickly in and out of these beds, with reductions in time spent on nursing documentation and bed turnover, resulting in shorter lengths of stay in ED. Using this process, we reduced the ED length of stay for ESI level 4-5 patients by 25%, despite an increase in census of 24%. This was done with no change in NP staffing hours, while also reducing the number of attending physician hours by 10%, for a cost savings of approximately $205,400 annually.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	$205,400	$	$ 205,400	☒

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS Dept. of Emergency Medicine Olive View-UCLA Medical Center 14445 Olive View Dr., Sylmar, CA 91342		**TELEPHONE NUMBER** 747-210-3107
PROGRAM MANAGER'S NAME Aristides Orue		**TELEPHONE NUMBER** 747-210- 3107 **EMAIL** aorue@dhs.lacounty.gov
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE (PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Lisa Finkelstein	**DATE** 7/2/2018	**TELEPHONE NUMBER** 213-288-8104 **EMAIL** lfinkelstein@dhs.lacounty.gov
DEPARTMENT HEAD'S NAME AND SIGNATURE Christina R. Ghaly, M.D.	**DATE** 7/2/2018	**TELEPHONE NUMBER** 213-288-8101 cghaly@dhs.lacounty.gov

We Support Plain Language

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1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project **to the County**. What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success **and specify assessment time frame**. Use Arial 12 point font.

Challenge: Historically, the Emergency Department (ED) and Urgent Care Clinic (UCC) at Olive View-UCLA shared triage resources. There was one point of arrival and check-in, and after triage, lower acuity patients would be sent to the UCC during their business hours, and the higher acuity patients would be seen in the ED. This was based on a commonly-used triage system called ESI that categorizes patients into 5 categories based on severity of illness and expected resources needed. ESI 1 indicates the highest acuity, with 5 being the lowest. Most ESI level 4 and 5 cases had been sent to be cared for in the UCC instead of the ED.

In August of 2016, the UCC split from sharing triage with the ED. Patients who wanted to be seen in the UCC would present themselves directly to the UCC for check in. Patients presenting to the ED would be seen in the ED. While we created signage and disseminated information to patients about the change, we found that many patients continued to sign in to the ED with lower acuity issues. This led to a large increase in the number of lower-acuity patients cared for in the ED. In the 2nd quarter of 2016, the ED saw 3,614 patients with ESI level 4-5; in the 4th quarter of 2016 that number increased to 6,125. The increased census of lower-acuity patients led to increases in ED waiting times and length of stay on busy days. The lower-acuity patients generally have the longest waiting times.

Our challenge was to revise ED patient flow and processes to accommodate the higher volume of lower acuity patients without adversely affecting our care of higher acuity patients, and without using additional resources.

Solution: The vision was to designate a section of the ED with a different workflow to optimize efficiency for lower acuity patients. This would benefit patients with shorter waiting times and shorter length of stay in the ED, resulting in an improved patient experience. We also hoped that it would reduce workloads on nursing by reducing some of the documentation that is typically done for higher acuity ED patients, but is not done for lower acuity patients in the urgent care setting. An additional benefit is reduced turnover time between patients in these rooms due to revised room layout and how patients are placed in rooms.

We selected an 8-bed pod in a portion of the ED in which the beds did not have cardiac monitors. The pod shares a single nursing station, with a provider workroom directly adjacent to facilitate coordination of care between nursing and providers. The standard patient room setup was altered to put the gurney against the wall, with chairs in the center of the room in which patients would be placed. By placing appropriate lower-acuity patients in chairs instead of gurneys we reduce the time needed to move patients in and out of rooms, and reduce the time needed for room turnover between patients.

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We use 2 Nurse Practitioner (NP) providers to staff the area; each teams with a nurse to be responsible for 4 beds. The NP and nurse coordinate to bring patients in and out of the rooms to maximize patient flow. Nursing documentation is reduced compared to what is done for higher acuity patients in other sections of the ED, and rooms can be turned over more quickly because most patients are seen in chairs, though the gurney is available for exams and treatment as needed. We utilize sub-waiting rooms within the ED to improve the efficiency of sending patients for X-rays and other imaging studies. Patients can be sent back to the waiting room if they are just waiting for laboratory or other test results, allowing more efficient use of limited ED rooms.

This was a collaborative project developed by ED Nurse Practitioners, Physicians and Nursing. While the concept of ED Fast Track areas is not particularly novel, this was a new workflow for our ED. There was concern in the development phase that setting aside an area to care for lower acuity patients more quickly might negatively impact the waiting times of higher acuity patients, in particular ESI level 3 patients who do not require immediate care and are often sent to the waiting room from triage. We planned to also measure the impact on waiting times for higher acuity patients. **Benefits:** The benefits from this project exceeded expectations. Comparing 2016 to 2017, we found that for ESI level 4-5 patients, we reduced median time to first seeing a provider from 1 hour 9 minutes to 1 hour zero minutes (13% reduction) and median length of stay decreased from 4 hours 3 mins to 3 hours 3 minutes (25% reduction). We made these improvements despite a 24% increase in census of level 4-5 patients (18,746 to 23,197). We also found that measures for ESI level 1-3 patients improved, though to a lesser extent. Median time to provider improved by 3% and median length of stay by 2%, despite a 2% increase in census of ESI level 1-3 patients.

In addition to the improvements in patient flow and customer experience, we were also able to recognize cost savings. More efficient use of NPs in this designated area reduced the time that patients spent in the waiting room. This allowed us to reduce the total number of hours of attending physician coverage in the ED by reducing the number of hours that attending physicians cover the Rapid Medical Exam area where we screen patients who are in the waiting room. This was during a time when the number of full-time physician items in the ED had been decreased, and we were experiencing occasional staffing shortages for part-time emergency physicians. From 2016 to 2017, we reduced the total number of hours of attending physician coverage by 10%, or a total of 2,054 hours.

Based on physician average coverage cost of approximately $100 per hour, this amounts to $205,400 annual savings in addition to the improvements in care efficiency and patient experience. Reduced waiting times and improved patient experience could reduce the number of patients who leave the waiting room before being seen, which would bring additional revenue benefits.

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Linkage to the County Strategic Plan – 1 page only. Which County Strategic Plan goal(s) does this project address? Explain how. Use Arial 12 point font.

GOAL III. Realize Tomorrow's Government Today
Strategy III.3 - Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability. Continually assess our efficiency and effectiveness, maximize and leverage resources, and hold ourselves accountable

The ED demonstrated its commitment to operational effectiveness and fiscal responsibility through this project by decreasing the length of stay, improving patient experience, maximizing the utilization of NP, and saving approximately $205,400 in labor costs.

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. Please indicate whether these benefits apply in total or on a per unit basis, e.g., per capita, per transaction, per case, etc. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes. Please indicate whether these are costs to the County or to other entities.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes. Please indicate whether these were expenditures by the County or by other entities.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	**$205,400** SAVINGS OF COUNTY EXPENDITURES	**$**	**$ 205,400**	☒

ANNUAL= 12 MONTHS ONLY

$100 per physician average coverage cost per hour X 2,054 hours = $ 205,400 savings

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FOR COLLABORATING DEPARTMENTS ONLY

(For single department submissions, do not include this page)

DEPARTMENT NO. 2 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE **EMAIL:**_____	**DEPARTMENT HEAD'S NAME AND SIGNATURE** **EMAIL:**_____
DEPARTMENT NO. 3 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE **EMAIL:**_____	**DEPARTMENT HEAD'S NAME AND SIGNATURE** **EMAIL:**_____
DEPARTMENT NO. 4 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE **EMAIL:**_____	**DEPARTMENT HEAD'S NAME AND SIGNATURE** **EMAIL:**_____
DEPARTMENT NO. 5 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE **EMAIL:**_____	**DEPARTMENT HEAD'S NAME AND SIGNATURE** **EMAIL:**_____
DEPARTMENT NO. 6 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE **EMAIL:**_____	**DEPARTMENT HEAD'S NAME AND SIGNATURE** **EMAIL:**_____
DEPARTMENT NO. 7 NAME AND COMPLETE ADDRESS	
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE **EMAIL:**_____	**DEPARTMENT HEAD'S NAME AND SIGNATURE** **EMAIL:**_____