SEE THE PROVIDER

NOT THE WAITING ROOM

From chest pains and concussions, to severe injuries and sudden seizures, the extraordinary staff at Penn Presbyterian Medical Center’s emergency department (ED) have seen it all and are ready 24/7 to provide patients with the care they need. But as is the case for thousands of EDs across the country, it can be challenging for staff and patients alike when the waiting room is filled with illnesses and injuries of varying levels. However, through the Presby EnhanceED initiative, PPMCs ED leaders are working hard to re-engineer workflows, address capacity challenges, and transform the patient experience.

Extreme Makeover, ED Edition
Since the Trauma Center moved to PPMC in 2015, patient volume has steadily increased and is now approaching 50,000 visits a year. The good news: the community recognizes that Presby’s exceptional care can get them back on the road to health. The challenge: overcrowding and long wait times in the ED can lead to frustration for everyone.

When patients are admitted but there are no inpatient beds available, they are temporarily boarded in the ED. “But if 20 beds are filled with boarders who are waiting 24 hours for a bed upstairs, that gives us fewer spaces to care for ED patients,” said Christopher Edwards, MD, chief of Emergency Medicine. “Less space means longer wait times,” which means a greater risk of patients leaving before their treatment is complete or before they are seen.

Now that the Presby EnhanceED initiative has retooled after its pandemic pause, the time has finally come to address these issues and create a better experience for patients and staff alike under the guidance of Edwards, Sean D. Foster, MD, assistant chief of Emergency Medicine, and a team of ED nursing leaders. The initiative includes innovative updates such as optimizing the triage process and developing a three-track patient flow model. As these changes are implemented, the team plans to continuously monitor three key metrics — length of stay (LOS), door-to-provider (D2P) time, and the number of patients who walked out of the ED before being seen or completing their treatment.

Over the coming months, the team aims to decrease the average LOS to under 90 minutes for non-acute patients, and to under 130 for patients with emergent needs. They also hope to reduce the D2P time to under 20 minutes, and to cut the number of patients who leave prematurely to under three percent. “They’re optimistic goals, but achievable,” Edwards said. “The faster we get patients in, the faster we can treat them, and the faster we can discharge them. All of that improves outcomes.”

Patient Flow Progress
On average, the PPMC ED sees 140 patients per day, about 65 percent of whom are discharged directly from the department. To reduce crowding, the team developed an improved flow model that sorts patients into three segments — acute care, mid track, and super track — that are shuttled to three separate areas. The Hospital of the University of Pennsylvania adopted a similar model last summer.

Each patient is assigned an Emergency Severity Index (ESI) level on a five-point scale, with 1 being the most acute cases, and 5 being the most stable cases. ESI 1 and 2 patients who are experiencing life-threatening issues like cardiac arrest, shortness of breath, traumatic injuries, or gastrointestinal bleeds are prioritized and immediately taken to the main ED, while less acute patients are triaged. After speaking with a provider, ESI 3 patients — such as those with abdominal pain, fractures, food poisoning, or high fevers — are segregated again, with more complex cases being diverted to the main ED, while less acute ESI 3s are placed in the newly designated mid track.

ESI 4 and 5 patients present with minor cuts, scrapes, or rashes, or who need prescription refills are placed on the super track and are moved to a nearby surge area outside of the ED. Mid track and super track patients can remain in their designated waiting areas as the physician orders any necessary testing or imaging. This frees up space in the ED while also placing non-acute patients in dedicated areas where they can be seen, treated, and discharge more quickly.

“Because of things that aren’t entirely in our control — volume, boarding times, space constraints — it can be challenging when patients leave before their care is completed, or frustrating when we know that someone has been waiting for hours,” said Lisa Triantos, MSN, RN, CEN, NE-BC, clinical director of Emergency, Medical, and Behavioral Health Nursing. “We can enhance the patient experience by making sure everyone gets where they need to go quickly and receives the right level of care in the right setting at the right time.”

Reimagining Roles and Transforming Triage
Traditionally, patients were welcomed by a registrar, triaged by a nurse, then sent back to the main waiting area until a room opened and a provider was available to treat them. Presby EnhanceED revises this process, shaking up the staffing model and introducing a few new key players in an effort to improve patient flow and satisfaction.

“The first person patients will see when they present at the ED will be a rapid assessment nurse. They’ll ask for the reason of the visit and evaluate the patient’s heart rate and pulse on level,” said LeighAnn Mazzone, RN, MSN, CEN, nurse manager of the ED. “That immediate connection with a clinician helps patients feel seen and like their health concerns are being taken seriously. If they’re really sick or injured, the patient will progress into the acute side of the ED. If not, they’ll go through the vertical flow process.”

Working seamlessly with the rapid assessment nurse are patient flow coordinators. While these valuable additions to the nursing team can’t wave a magic wand and create more beds, they can ensure that patients move through the department smoothly and help clinicians clearly communicate waiting times so patients know what to expect. The patient flow coordinators also connect patients with providers-in-triage.

“Triage has historically been a nursing function, but we’re taking a more flexible, team-based approach,” Triantos said. Embedding providers in the front end of the triage process can expedite decision making about patient treatment plans, shorten D2P times, and reduce rates of patients leaving without being seen. Meanwhile, the nursing team can turn their attention to providing hands-on for the patients.

Edwards noted that the ED staff have offered overwhelmingly positive feedback. “They really see the value in this approach, and they’ve been very engaged,” he said. “When we fully go live in January, I know we’re going to knock this out of the park.”

ACUTE CARE

SUPER TRACK

MID TRACK

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OCTOBER 2020
Progress is constant at PPMC. Just a few months opening the doors of the comprehensive new radiation oncology and infusion suite in May, the floor above the suite was transformed with two of its four planned operating rooms in an effort to better manage growing demand for surgery. For Mark Alan Pizzini, MD, associate executive director of Perioperative Services and chief of Anesthesiology and Critical Care, PPMCs ability to forge ahead with these plans even in challenging times demonstrates the hospitals dedication to creating state-of-the-art advancements that keep Penn Medicine the premier health system in the region.

In the Q&A below, Pizzini shared more details about the process of opening the new ORs amid a pandemic and what they offer for PPMCs patients.

Q: Completing this project amid COVID-19 must have been a challenge! What was that process like?
A: It takes a village to successfully plan, design, and execute projects like this. It is definitely a team-driven process, and takes a lot of hard work from many people to make it successful. Our nursing, anesthesia, facilities, regulatory, pharmacy, and IS teams — and more! — all played integral parts in this project.

As for the timeline, we were approaching our scheduled completion dates for the first OR in April when COVID-19 hit. The pandemic led to a complete restructuring of all capital projects across the health system. In an effort to flatten the curve, PPMC also postponed surgeries where possible, and our daily OR volume plummeted. There were times in late March and April where we were concerned that we wouldn’t have either the volume or capital to complete the ORs in the foreseeable future! Fortunately, as COVID-19 numbers waned and patients whose care had been delayed returned to the hospital, our senior team was able to move forward on the OR project to meet our patient-care needs. In August, the state’s Division of Acute and Ambulatory Care visited and gave us the thumbs up to open.

Q: What sets these ORs apart, and what impact will they have on patients and staff?
A: The ORs have state-of-the-art equipment, monitors, and lighting, as well as new terrazzo flooring. They were designed with laminar air flow ventilation, which uses positive pressure currents to direct air away from the operative field in order to prevent contamination. Not all ORs can accommodate all types of surgical cases due to size and technology limitations, so the flexibility of the new ORs allows them to handle virtually every type of surgical case, including advanced spine and cardiac cases. This gives our staff much greater ability to provide whatever surgical care is required, resulting in improved patient outcomes. We also expect that the patient experience will improve with the reduction in wait time for care.

Q: How does the opening of these ORs and the plans for two more reflect PSMs growth goals?
A: PPMC is invested in expanding surgical care is required, resulting in surgical care needed. In August, the state’s Division of Acute and Ambulatory Care visited and gave us the thumbs up to open.