What is ED Operations?

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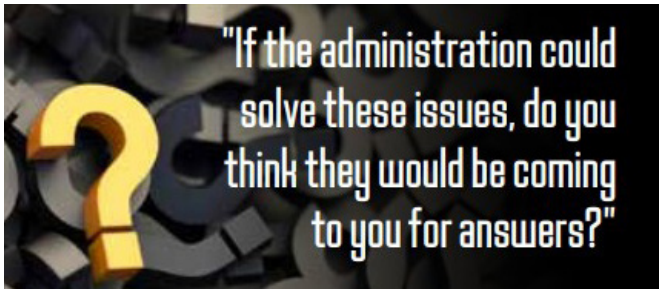
After single handedly trying to empty the city of New Orleans of its oyster supply at SA, I had a great time helping to man the booth for the Operations Management Committee (now the Operations Management Section). I recently graduated from the AAEM ED Operations Certificate course and I was a little nervous because I thought people would expect me to be an expert in ED ops. It turns out the most frequent question that I got was "What is ED operations?"

ED operations is about developing a systematic approach to solving problems. While it's most useful for ED directors/assistant directors, everyone needs to know something about operations as it affects our ability to care for our patients. Most residents get some exposure to this subject in their last year of residency, where they are typically in charge of patient flow in the department and putting out the daily fires that inevitably occur. What most graduating residents don't realize is that, over the span of their career, the greatest challenge will not be the medicine, but how to decompress your packed waiting room, handle patient complaints, keep administration happy, and maintaining healthy relationships with nursing and ancillary staff. Here are some examples of the problems we face daily.

Problem One

Your waiting room times have increased by 20% and left without being seen numbers have now topped 6%. Your administration wants to set up a meeting next week to deal with "the problem." How do you respond? One way to respond would be to mention that hospital boarding times have increased, beds aren't being cleaned due to labor shortages and your nurses are already stretched too thin. If the administration could solve these issues, do you think they would be coming to you for answers?

Instead, focus on what you can control, which is the ED itself. How should you look at the data? Perhaps create a value stream map of each process a patient goes through and see what actually adds value. Is your triage process too long? How about quick registration and a pull to full model where most triage occurs in a bed? Does that bed have to be an actual bed, could it be a chair or hallway? You might calculate the percentage of high acuity patients and adopt a split flow triage, where low acuity patients are evaluated and placed back in the waiting room awaiting results. Maybe it's your coverage. You calculate the patient arrivals by hour versus physician shifts and find that the 12a-12p shift should really be a 9a-9p shift.



Armed with this data, you go to the meeting and propose a split triage model with bedside registration and pull-to-full when beds are available along with adjusting physician coverage and propose to measure the outcome by tracking triage times, door

to doc times, door to disposition times, and LWBS percentages.

Problem Two

You were just appointed ED director two years out of residency at your hospital, mainly because nobody else seemed willing to do the work. After two weeks on the job, your hospital CEO comes to you and says "Something needs to be done about Dr. Jones." With a frightened look on your face, you ask what's wrong, expecting some clinical deficiency. It turns out that Dr. Jones has been with the group for 15 years and is an excellent clinician, but administration over the past six months has received multiple complaints from nursing that he is belittling and frequently screams at staff when he perceives that they are not working fast enough. How do you approach someone that has been at your hospital far longer than you have?

This would be a good time to develop a formal plan for approaching these matters. This might include an initial information gathering where you talk to the people directly involved, you then formulate a plan and script prior to the meeting and you start with an informal conversation with the assistant director present as your witness. Your process then includes a period of monitoring and a formal letter if no improvement is made. If there is no response to the formal letter, you have either reviewed the medical staff policies on physician conduct or helped draft them yourself so that formal action can be taken.

Armed with this plan, you have a meeting with Dr. Jones and find out that he is in the middle of a divorce involving a bitter child custody battle. You suggest a peer coaching program offered by the hospital and he seems surprisingly receptive. Six months later the CEO comes back to you and asks how you were able to change his behavior. The CEO is pleased that his problem is solved, Dr. Jones is again a happy and productive clinician and you are relieved that you were able to handle the situation.

These are some of the issues that ED operations focuses on. Want to learn more? Join the Operations Management Section.

ACKNOWLEDGMENT:

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