Containing Cost While Providing Prudent Care

Jay Kaplan, MD, FACEP

Physician coach/consultant/mentor

Former Medical Director of Care Transformation,
LCMC Health

Clinical Associate Professor of Medicine,
LSU Health Sciences Center
University Medical Center New Orleans

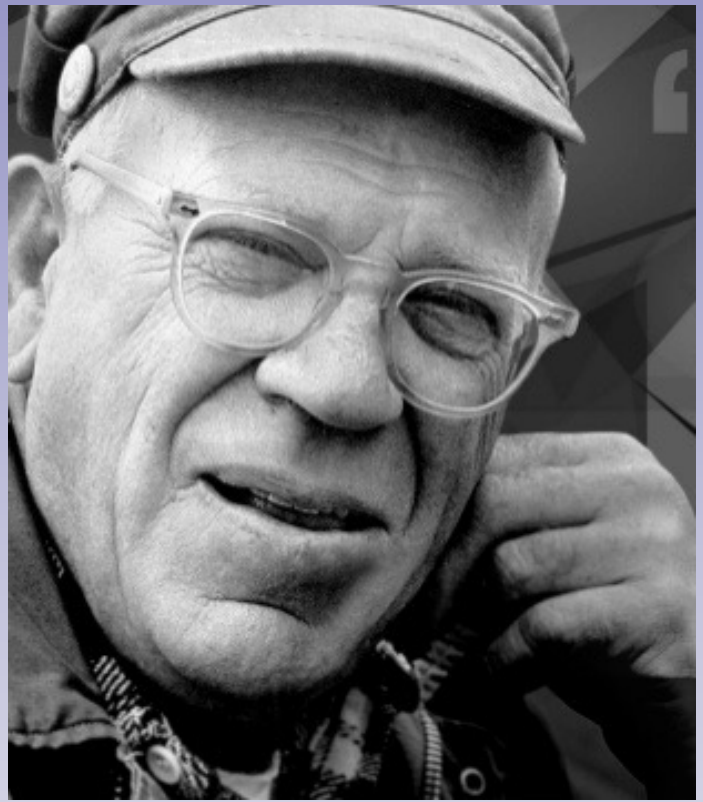
Caveat #1:
What Brought Us to this Dance . . .

Ain’t Going to Get Us to the Next One . . . .

Caveat #2 –
The Best Definition of Madness is

To keep doing things
the same way
and expect different results . . .

Caveat #3
How Most of Us Approach Change



“In times of change, learners will inherit the earth while the learned find themselves beautifully equipped to deal with a world that no longer exists.”

Social Philosopher Eric Hoffer

Outline

- Definition of “Resource Utilization” and “Cost Containment”
- Major types of over-utilized resources: Staff/Imaging/Lab/Inpatient admissions
- “Wasted Bed Capacity”
- Tools available to assist in this process
- Physician profiling and change management

Definitions

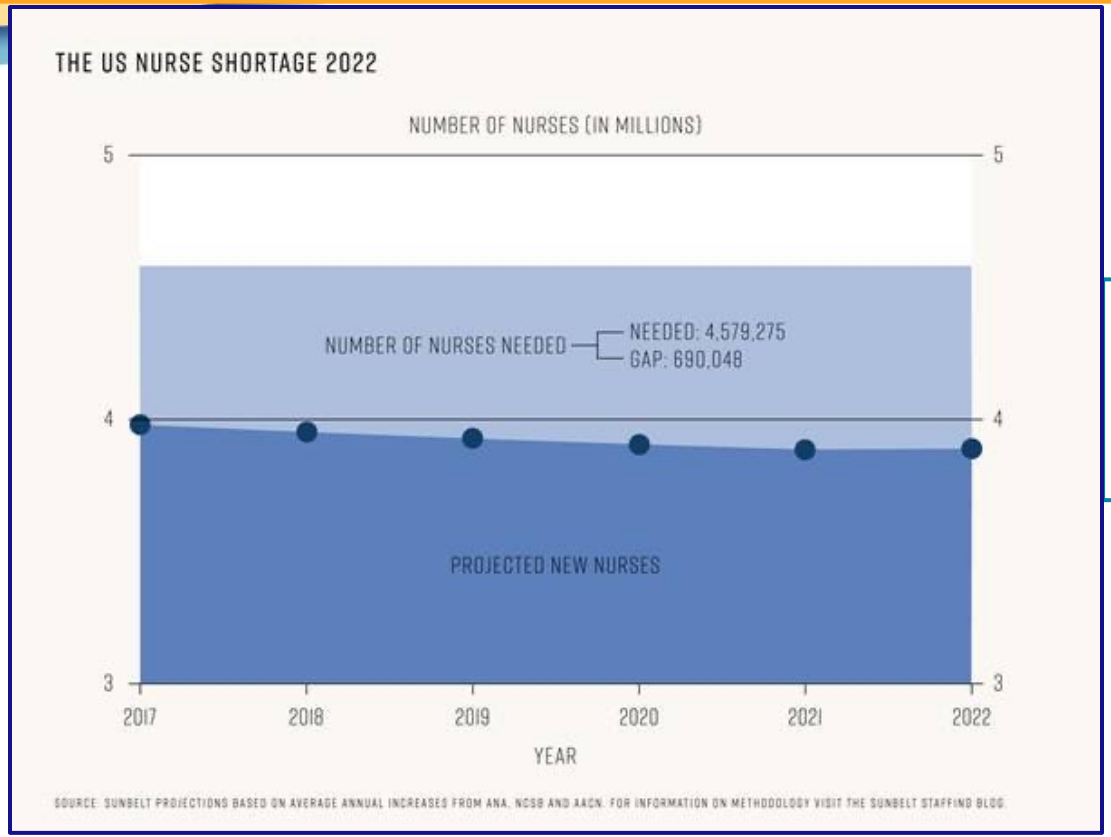
- Resource Utilization:
  - The percentage of time a resource is busy
  - Use compared to availability
- Cost Containment:
  - A wide variety of strategies or methods whose primary goal is to control the rising cost of health care. These strategies and methods may include, but are not limited to government regulation, managed care programs, payment policies, global budgets, rate setting, consumer education, and utilization management

Capacity Vs. Demand - IHI

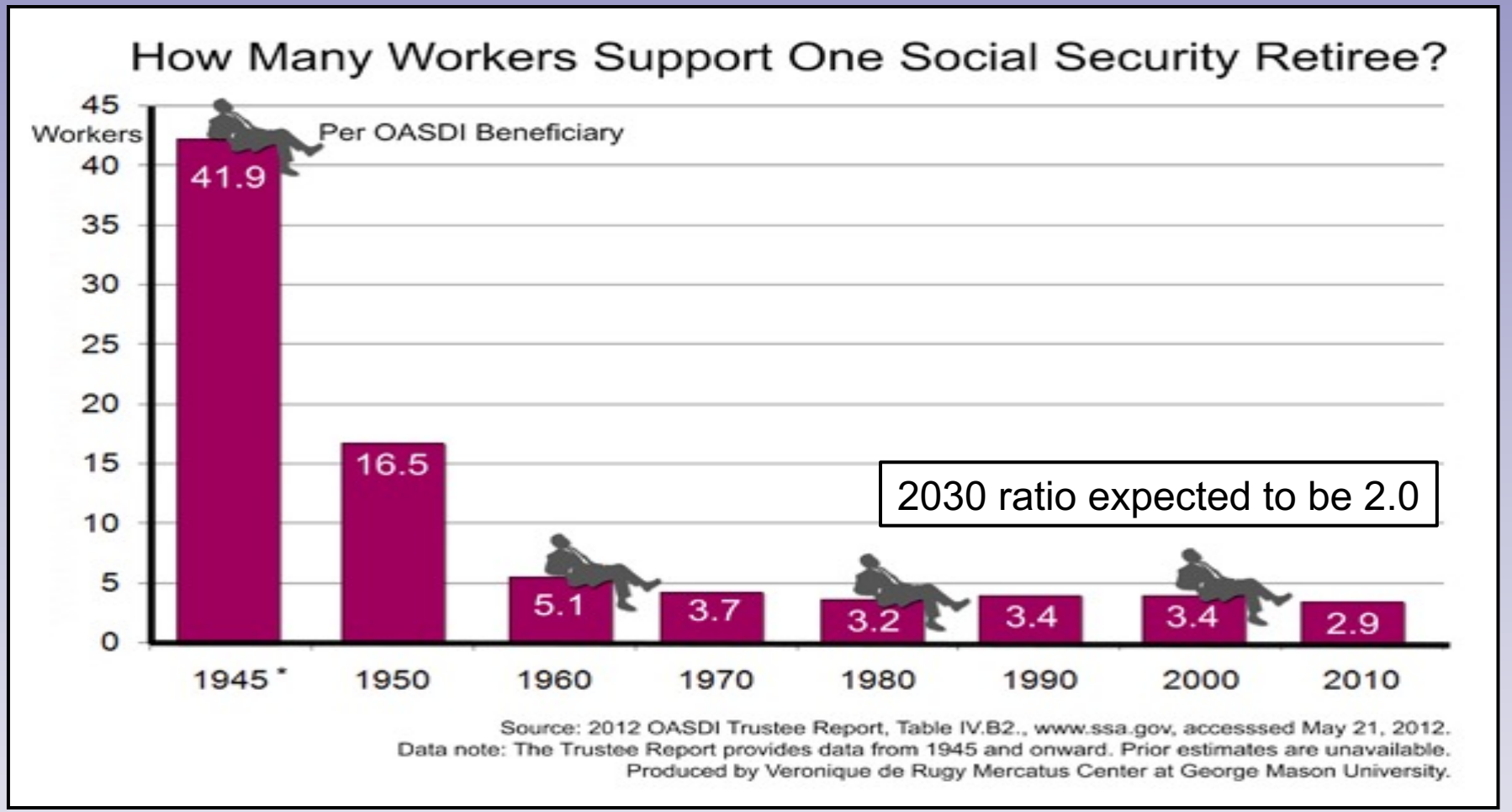
- Matching capacity and demand by making minor adjustments in the availability of health care providers or the scheduling of elective surgeries is often sufficient to reduce delays. If the demand for care is greater than the capacity of the system, there will be a delay in providing care. If the capacity is greater than demand, then resources are being wasted. When capacity and demand are matched, delays in care are reduced. Whenever a quantitative analysis indicates that the system has the capacity to meet the demand during normal functioning, then specific change concepts can be implemented relatively quickly to help align capacity and demand during predicted or unpredicted periods of high demand.

Cost = $$ Spent – Benefit

Why Is This Important?
Example #1: Workforce Shortage

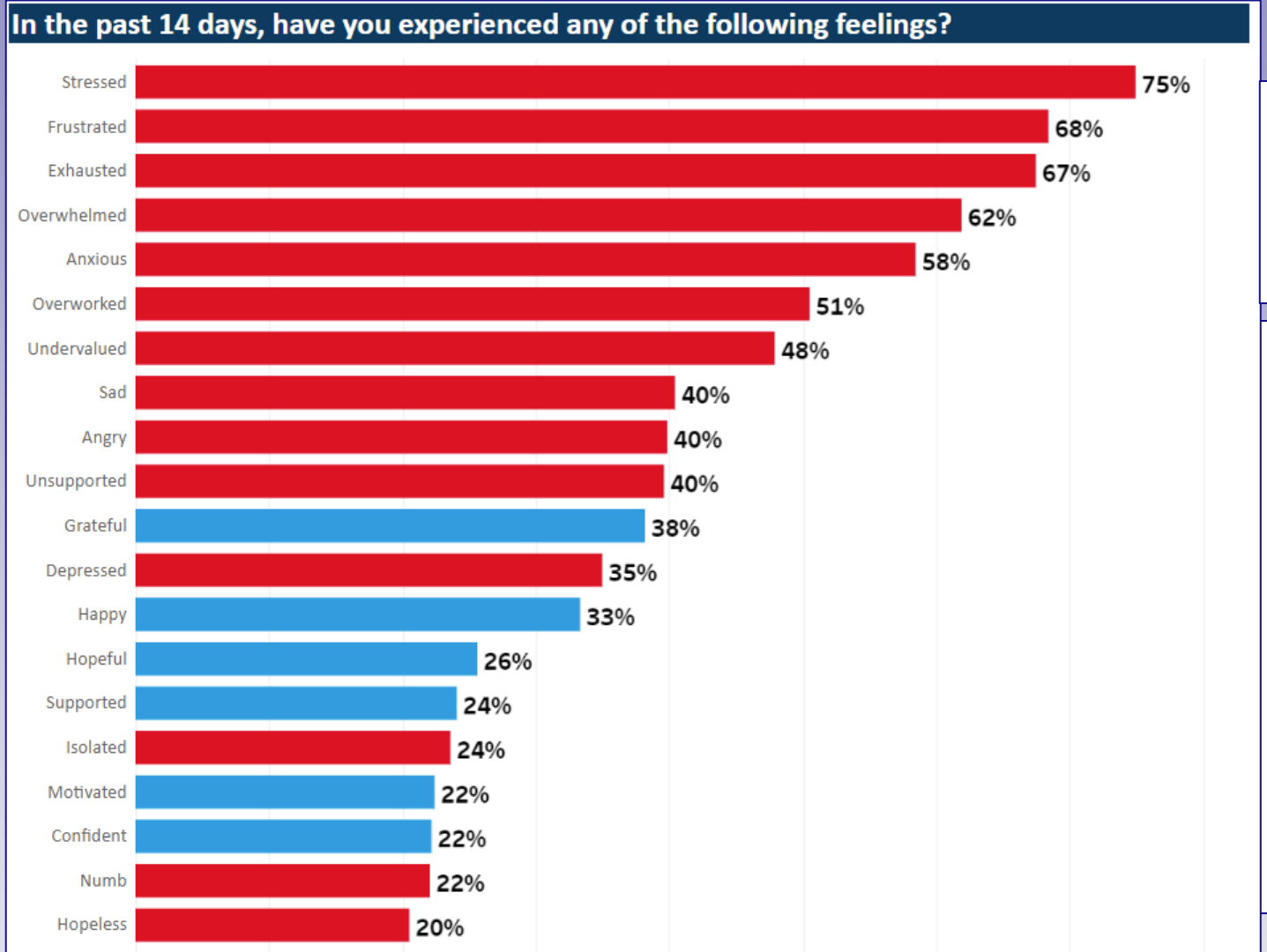


Average cost to replace:
Med-Surg $40-52,000
Critical Care $70-80,000


How Many Workers Support One Social Security Retiree?
45
Workers
40
35
30
25
20
15
10
5
0
Per OASDI Beneficiary
41.9
16.5
5.1
3.7
3.2
3.4
3.4
2.9
1945 *
1950
1960
1970
1980
1990
2000
2010
2030 ratio expected to be 2.0
Source: 2012 OASDI Trustee Report, Table IV.B2., www.ssa.gov, accesssed May 21, 2012.
Data note: The Trustee Report provides data from 1945 and onward. Prior estimates are unavailable.
Produced by Veronique de Rugy Mercatus Center at George Mason University.

Turnover amidst the Pandemic

- Since 2016, the average hospital turned over about **90%** of its workforce and **83%** of its RN staff.
- Hospitals in the Southeast had the highest RN turnover rate in 2020 of 24.9%, 7.2 % increase from 2019.



American Nurse Foundation Survey
(9,572 nurses)
August 2021

Stressed	75%
Frustrated	68%
Exhausted	67%
Overwhelmed	62%
Undervalued	48%
Hopeless	20%
Grateful	38%
Happy	33%
Confident	22%

Example #2: Revenue Maintenance

If X = healthcare $,
and Y = # of people utilizing that healthcare, then . . .
Z = healthcare $/person

***

If X stays ~ the same, and Y increases dramatically,
Z will decrease dramatically

***

Every day 10,000 Americans turn 65 years of age

"Here you go . . . thought you might like this"

Not . . .

Problems:

- We are still viewed as “the most expensive place in the health care system to receive care.”
- We are the #1 target for ACO’s and organizations committed to value-based payment.
- And . . . Medicaid in most states is the single largest line item in the budget!
- AND . . . In terms of admissions and other costs, EP’s control 32%!

An Interesting Study by Myles Riner

- 20% of least costly non-admitted ED visits account for 4% of the total cost of all non-admitted ED visits.
- Could save as much $ if reduce CT scans 1/12.

Responsibilities

- Conduct an analysis of programs designed to impact low value care efforts in other states, within Louisiana, and inside LQN.
- Develop strategies and leverage technology to explore improvement opportunities that will impact low value care.
- Identify, share and promote best practices within LQN that will identify and fill knowledge gaps, generate creative and innovative ideas, lead to improvements in overall patient care, and result in responsible planning and management of Medicaid resources.
- Promote education and engagement in patient safety, quality improvement and care transitions elements for attending physicians, residents, medical students and advanced practice professionals.
- Meet other deliverables related to the MCIP Program as assigned by the Quality Subcommittee

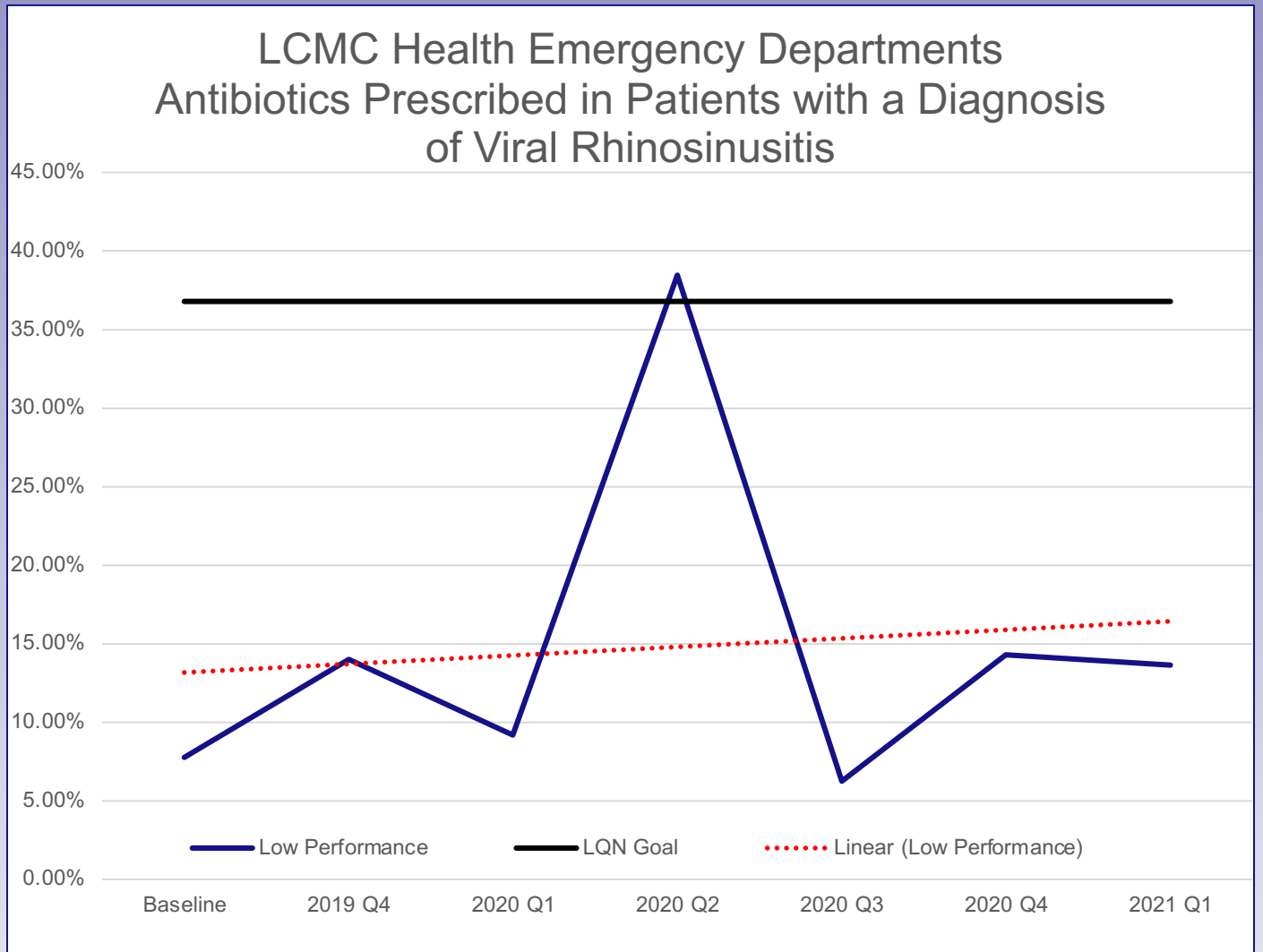
MCIP Target Guidelines

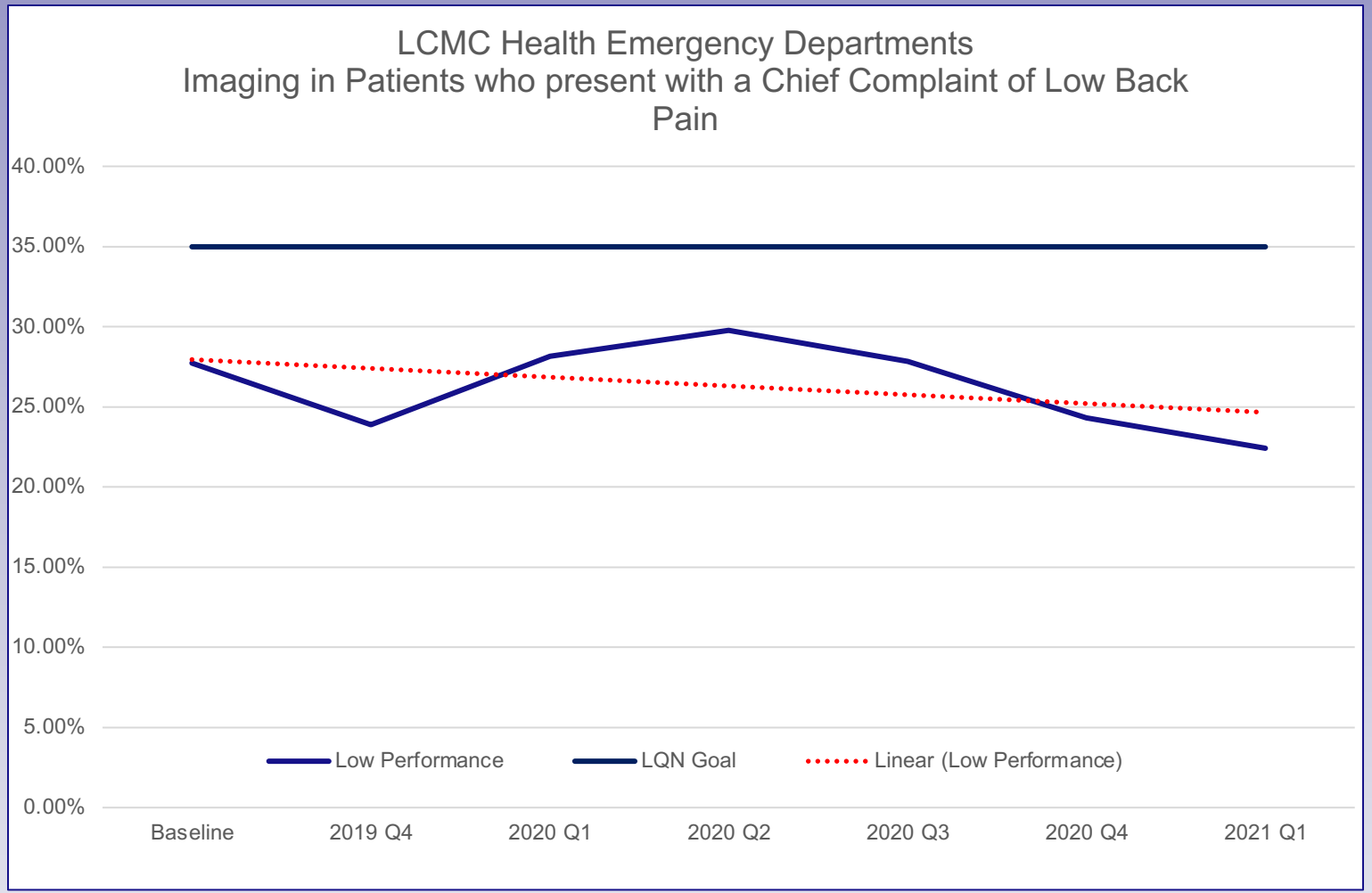
The Louisiana Quality Network Promoting Evidence-based Practice/Reducing Low Value Care Committee has chosen to focus its efforts on:

- Avoid prescribing antibiotics in the emergency department (ED) for uncomplicated sinusitis (Target Guideline A)
- Avoid lumbar spine imaging in the ED for adults with non-traumatic back pain unless the patient has severe or progressive neurologic deficits or is suspected of having a serious underlying condition (such as vertebral infection, cauda equine syndrome, or cancer with bone metastasis) (Target Guideline B)

MCIP Educational Actions

- Educate existing medical staff (MD, NP, PA, Residents) and nursing staff using the letter provided to LQN facilities for the purpose of explaining the MCIP program and socializing baseline performance for Target guidelines A & B.
- Educate medical staff (MD, NP, PA, Residents) using the EBP Grand Round presentation titled *"Promoting Evidence-Based Practice and Reducing Low Value Care – LQN Target Guidelines"* and *"The Evidence Behind the Target Guidelines in the Treatment of Patients with the Complaint of Low Back Pain and the Diagnosis of Sinusitis."*
- Educate medical staff (MD, NP, PA, Residents) and nursing staff of available patient/provider educational material for Targets A & B, including the *Choosing Wisely*® materials.
- Provide online references, including UpToDate for evidence-based practices intended for uncomplicated sinusitis and low back pain.
- Follow through on education regarding the ACR Select Appropriate Use Criteria software implemented within the Epic electronic health record.
- Develop and implement Best Practice Advisories (BPA's) to remind physicians within their normal work-flow of the target guidelines and encourage consistent utilization of the guidelines.


LCMC Health Emergency Departments
Antibiotics Prescribed in Patients with a Diagnosis of Viral Rhinosinusitis
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Low Performance
LQN Goal
Linear (Low Performance)
Baseline
2019 Q4
2020 Q1
2020 Q2
2020 Q3
2020 Q4
2021 Q1


LCMC Health Emergency Departments
Imaging in Patients who present with a Chief Complaint of Low Back Pain
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Low Performance
LQN Goal
Linear (Low Performance)
Baseline
2019 Q4
2020 Q1
2020 Q2
2020 Q3
2020 Q4
2021 Q1

In Terms of $ Cost, the Real Questions Are

- Do you need to order that imaging study on that patient?
- Do you really need to admit that patient?
- Status: Observation or Inpatient?
- Level of Care: Med/Surg or Tele or ICU?

and . . .

- Are all of your clinicians making those decisions in a consistent way?

In Terms of $ Cost, the Next Question Is

- Are you giving your clinicians individual feedback on their:
  - Resource utilization
  - Throughput metrics
  - Admission/Observation %'s
  - Patient experience
  - Relationship with staff
  - Relationship with peers
  - Relationship with medical staff/resident staff?

PHYSICIAN EVALUATION

Physician Name: _____

Evaluation: 90 Day, 6 Month, _____ Year

Date: _____

	Poor	Fair	Average	Good	Excellent	N/A
CLINICAL PERFORMANCE:						
Overall Knowledge:	1	2	3	4	5	6
Knowledge of the Clinical Literature:	1	2	3	4	5	6
Judgment:	1	2	3	4	5	6
Speed:	1	2	3	4	5	6
Q/A Issues:	1	2	3	4	5	6

Physician score:

Patients per service hour: _____

RVU's per service hour: _____

% 72 hour returns admitted: _____

COMMENT(S): _____

_____

_____

Overall: _____

COMMENT(S): _____

_____

_____

Questions

- Is ordering the appropriate study equivalent to quality?
- Is not ordering the unneeded study equivalent to quality?
- Is working fully staffed more likely to produce quality?
- Is working short less likely to produce quality?

Choosing Wisely 2013

ACEP Announces List of Tests As Part of Choosing Wisely Campaign

October 14, 2013

In Monday's ACEP13 Opening Session, ACEP announced its list of five tests and procedures that may not be cost effective in some situations and should prompt discussion with patients in order to both educate them and gain their agreement regarding avoidance of such tests and procedures, when appropriate. These recommendations are part of ACEP's participation in the "Choosing Wisely®" campaign.

The mission of "Choosing Wisely" — a multi-year effort of the ABIM Foundation — is to promote conversations among physicians and patients about using appropriate tests and treatments and avoiding care when harm may outweigh benefits. Since launching in April of 2012, more than 80 national, regional and state medical specialty societies and consumer groups have become "Choosing Wisely" partners. ACEP officially joined the campaign in February.

"Overuse of medical tests is a serious problem, and health care reform is incomplete without medical liability reform," said ACEP President Alex Rosenau, DO, FACEP. "Millions of dollars in defensive medicine are driving up the costs of health care for everyone. We will continue to encourage the ABIM Foundation and its many partners in this campaign to lend their influential voices to the need for medical liability reform."

ACEP's five recommendations were developed through a multi-step process that included research and input from an expert panel of emergency physicians and the ACEP Board of Directors.

The 5 Initial Recommendations

1. Avoid computed tomography (CT) scans of the head in emergency department patients with minor head injury who are at low risk based on validated decision rules.
2. Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can void, or for patient or staff convenience.
3. Don’t delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.

The 5 Recommendations

4. Avoid antibiotics and wound cultures in emergency department patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up.
5. Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in uncomplicated emergency department cases of mild to moderate dehydration in children.

Choosing Wisely 2015: The Second 5

6. Avoid CT of the head in asymptomatic adult patients in the emergency department with syncope, insignificant trauma and a normal neurological evaluation.
7. Avoid CT pulmonary angiography in emergency department patients with a low-pretest probability of pulmonary embolism and either a negative Pulmonary Embolism Rule-Out Criteria (PERC) or a negative D-dimer.

The Second 5

8. Avoid lumbar spine imaging in the emergency department for adults with atraumatic back pain unless the patient has severe or progressive neurologic deficits or is suspected of having a serious underlying condition, such as vertebral infection or cancer with bony metastasis.
9. Avoid prescribing antibiotics in the emergency department for uncomplicated sinusitis.

The Second 5

10. Avoid ordering CT of the abdomen and pelvis in young otherwise health emergency department patients with known histories of ureterolithiasis presenting with symptoms consistent with uncomplicated kidney stones

So . . . Questions for You

- What have you done to implement the Choosing Wisely recommendations?
- What have you done to make your clinicians' practice more consistent?
- How have you demonstrated to your leadership (hospital, health system, state legislators) how you are containing cost while providing prudent/quality care?

The Real Question is not . . .

“Quality vs Cost”

but rather

“How to **Engender Quality** and **Generate** $
through

Cost-Effective **Throughput** and

Effective Use of Resources”

The Real Issue is Not $ Spent . . . But

What Do You Get

for the $$

You Spend?

The Real Issue is Not $ Spent . . . But

You have to learn to talk

the language of VOI . . .

Value on Investment

Return on Investment UMC (2019)

Increased Admissions/ Observation	1295 patients
Increased Visits/Patients treated	3168 patients
Additional patients seen who didn't LWOBS	51 patients

RETURN ON INVESTMENT - UMC (2019)

Of Admissions/ Observations

- 55.2% Admissions
- 31.3% Observations
- 13.5% Psychiatric Admissions

CHILDREN'S HOSPITAL | touro | UMC NEW ORLEANS REV. AVERY C. ALEXANDER ACADEMIC RESEARCH HOSPITAL | NOEH NEW ORLEANS EAST HOSPITAL | West Jefferson Medical Center | LCMC HEALTH

AVERAGE COLLECTED REVENUE (2019)

- Inpatient $16,873
- Observation $2,376
- Psych inpatient $4,699
- Discharged $442

CHILDREN'S HOSPITAL
touro
UMC NEW ORLEANS REV. AVERY C. ALEXANDER ACADEMIC RESEARCH HOSPITAL
NOEH NEW ORLEANS EAST HOSPITAL
West Jefferson Medical Center
LCMC HEALTH

RETURN ON INVESTMENT 2019

- Inpatients: 1295 x 55.2% = 766 patients x $16,873 = **$12,924,718**
- Obs: 1295 x 31.3% = 405 patients x $2,376 = **$962,280**
- Psych IP: 1295 x 13.5% = 175 patients x $4,699 = **$822,325**
- Total for Admits/Obs = **$14,709,323**

Plus

- Treated-and-Released: 51 patients (decreased LWOBS) = 51 x $442 = **$22,542**

Total increase in revenue = **$14,731,865**

RETURN ON INVESTMENT (2018 & 2019)

2018 = $15,524,027

2019 = $14,731,865

Total increase in revenue =

$30,255,892

The Cost-Effective Use of Human Resources . . .

- Ensure that no one is doing something that could be done by someone who costs less!

(but has the skills and knowledge to get the job done well)

Patient Care Technicians

The Care Pair Concept: Nurses

- Transport
- Do EKG's
- Draw blood
- Take/document vital signs
- Document "patient resting comfortably"
- Change stretcher linen
- Take bedpans
- Enter orders/write order slips

Clinical Information Managers - Scribes

The Care Pair Concept: Physicians

- Transcribe
- Document
- Gather lab results
- Know when x-rays are completed
- Follow up on consultants called
- Change stretcher linen
- Take bedpans
- Enter orders/write order slips

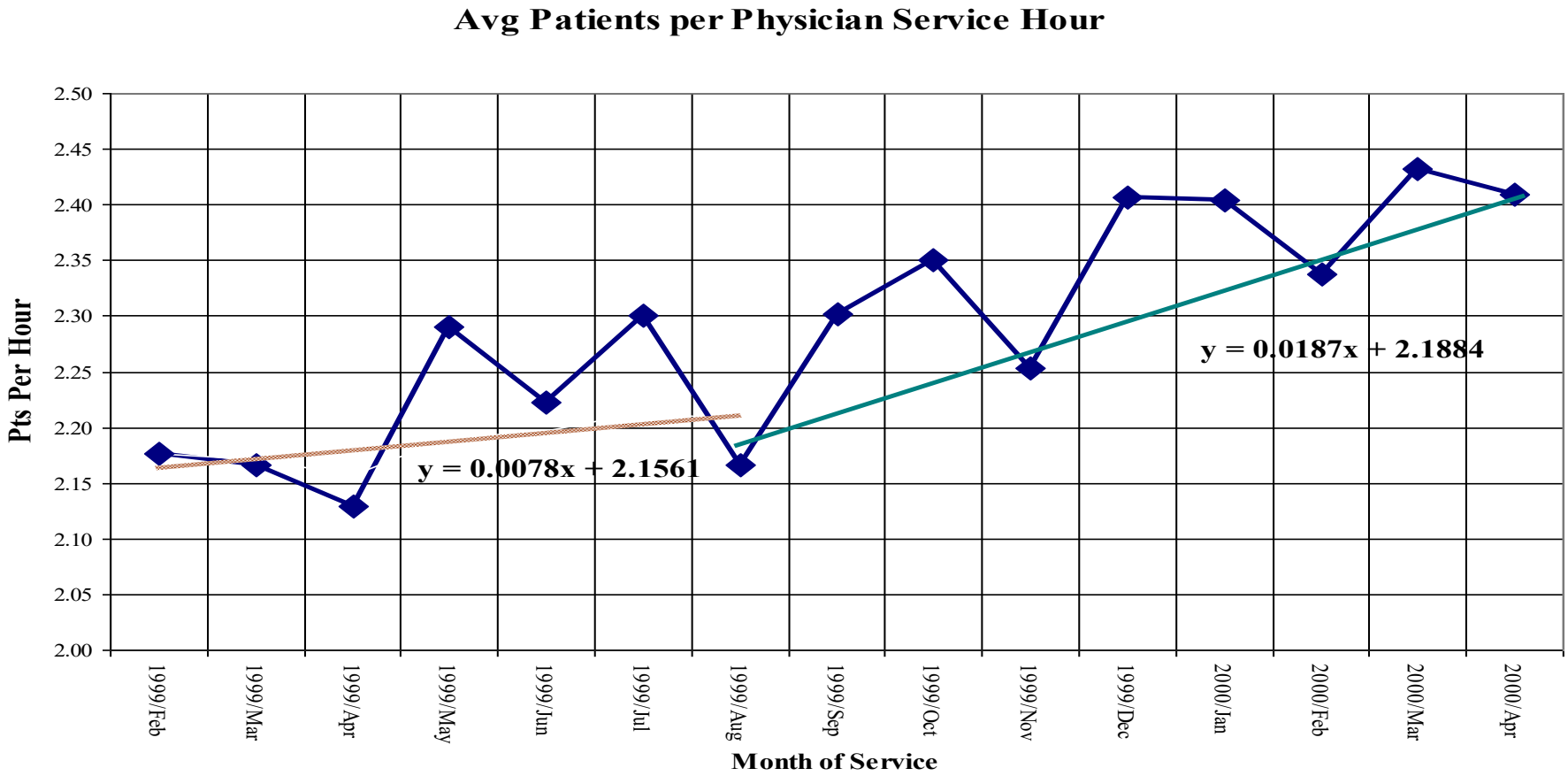
More Techs, APC's, Scribes

Staffing – Resource Allocation

- Dedicated Consistent Charge RN
- Charge/Lead Physician
- Flexibility:
  - Floats
  - Liberal use of extenders
  - CIM's/Medical scribes
  - On-call
- Geographic allocation?:
  - Nurse, Physician, both?

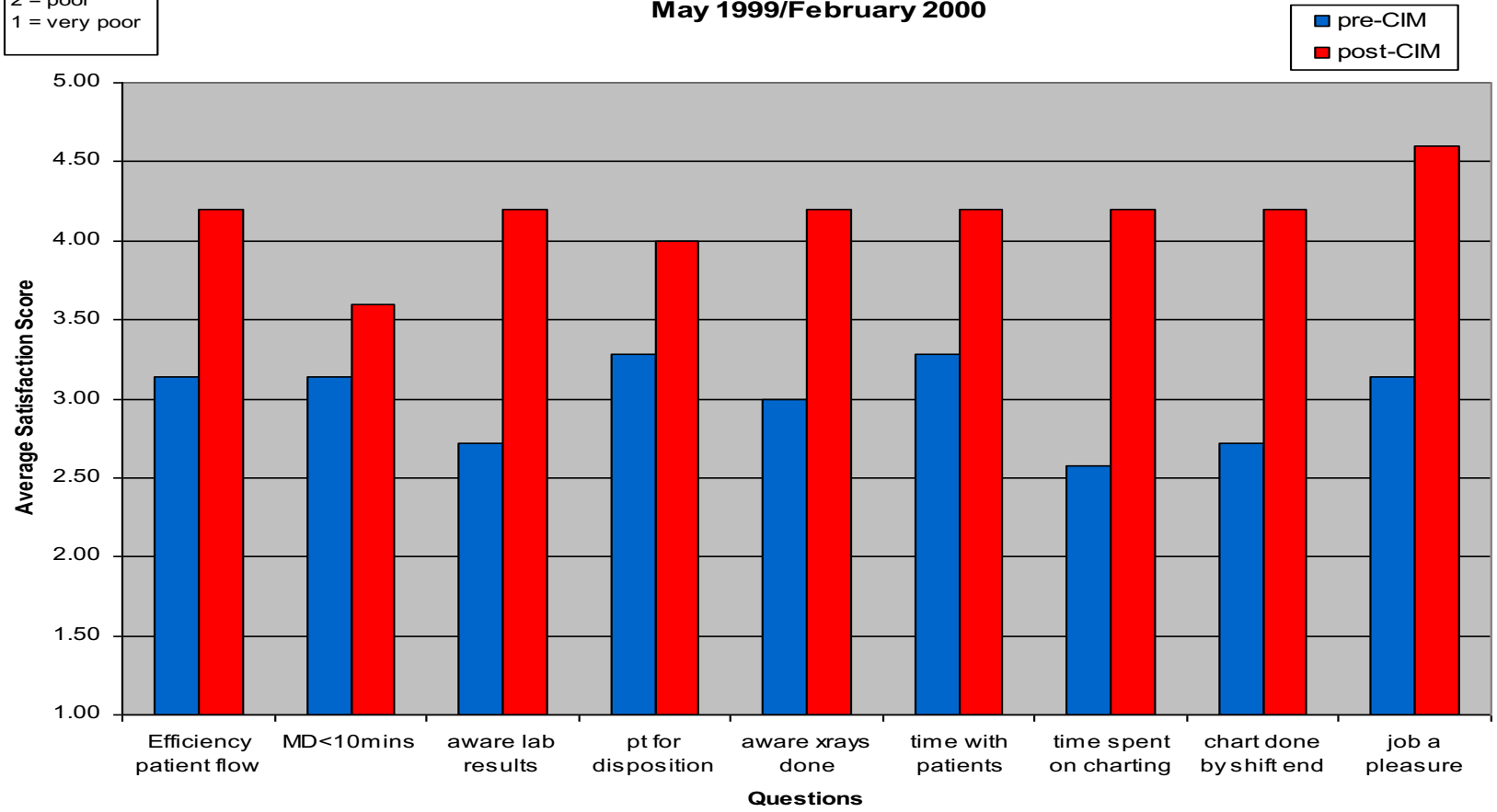
Clinical Information Managers = Scribes

- Go to bedside with you
- Document history and physical exam
- Follow up and alert you re: outstanding lab/ x-ray
- Follow up on requested communication
- Discharge instructions


Avg Patients per Physician Service Hour
Pts Per Hour
2.50
2.45
2.40
2.35
2.30
2.25
2.20
2.15
2.10
2.05
2.00
y = 0.0078x + 2.1561
y = 0.0187x + 2.1884
1999/Feb
1999/Mar
1999/Apr
1999/May
1999/Jun
1999/Jul
1999/Aug
1999/Sep
1999/Oct
1999/Nov
1999/Dec
2000/Jan
2000/Feb
2000/Mar
2000/Apr
Month of Service

5 = very good
4 = good
3 = fair
2 = poor
1 = very poor

Quality of Life for Emergency Physicians
Pre- and Post-Implementation of Clinical Information Managers
May 1999/February 2000



The Cost-Effective Use of Space - Throughput

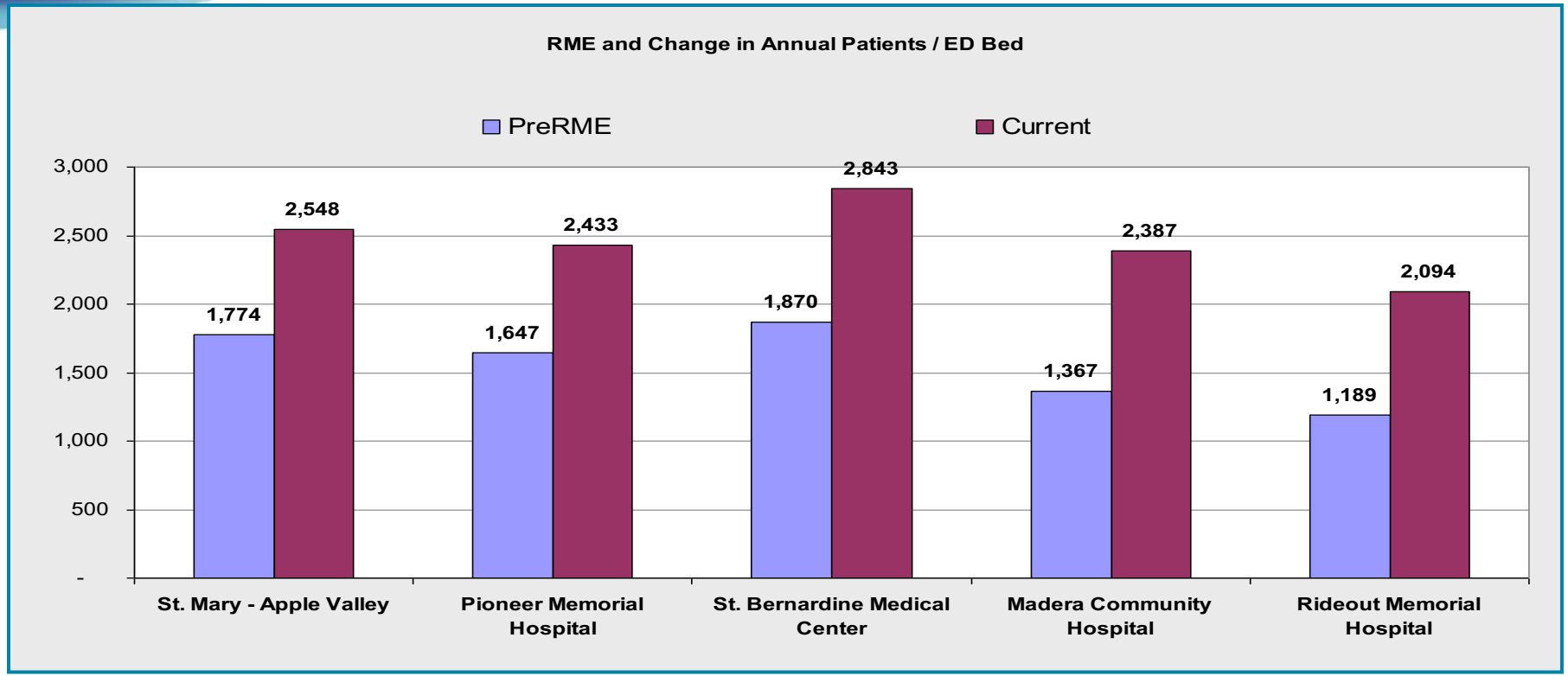
- Quick Registration
- Intake, not Triage
- Immediate Bedding
- RME: Treat-&-Street from Front/Initiate Care on Others
- Advanced Nurse Protocols

↓ Door to Doc

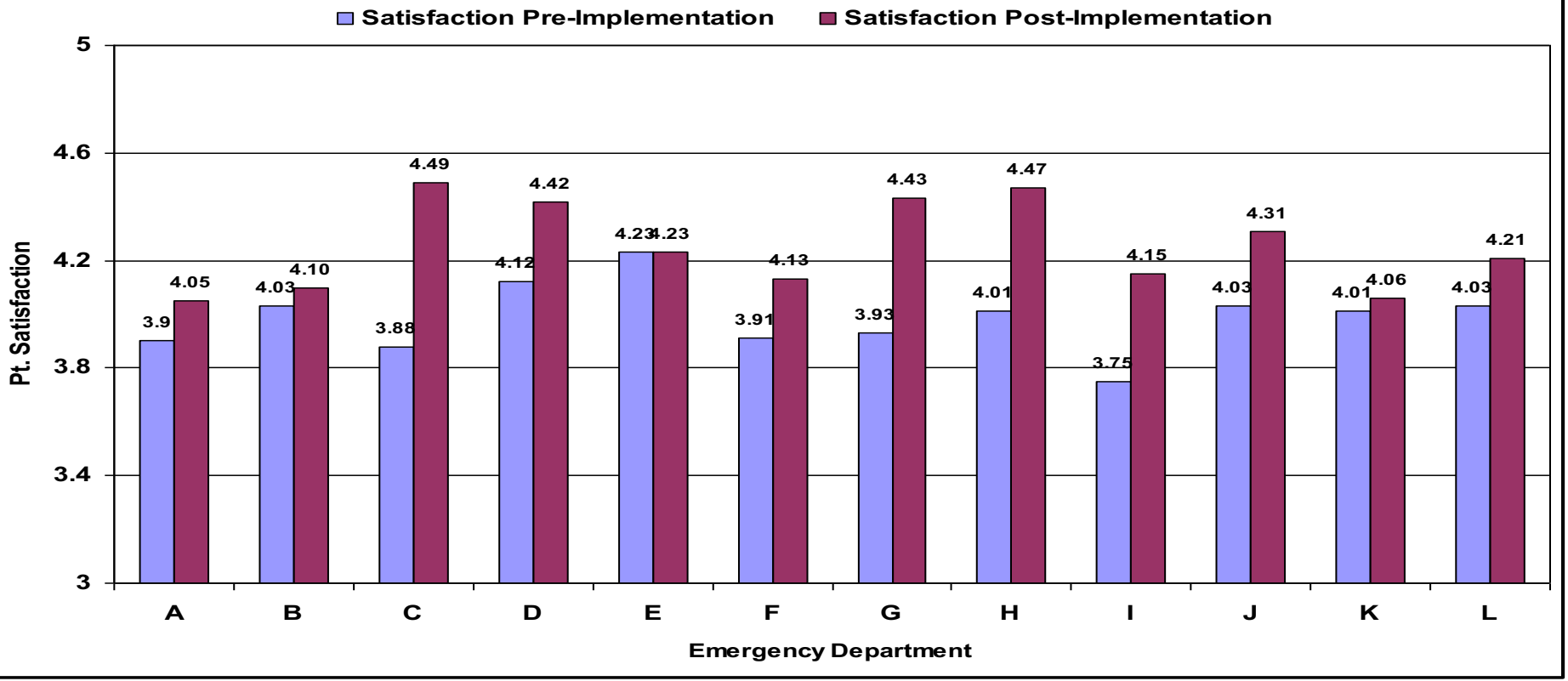
↑ Patient Experience


Fast ER
Treatment Area
If you prefer to wait in the ER lobby, please let us know.
Si usted prefiere esparar en la sala de espera en Urgencias, favor de avisarnos.

RME and Effective Bed Utilization



Impact of a Rapid Medical Evaluation Program on Patient Satisfaction (5 point scale)



Re-Look at Your Space & Align It to Your Process


PARDON
OUR
MESS

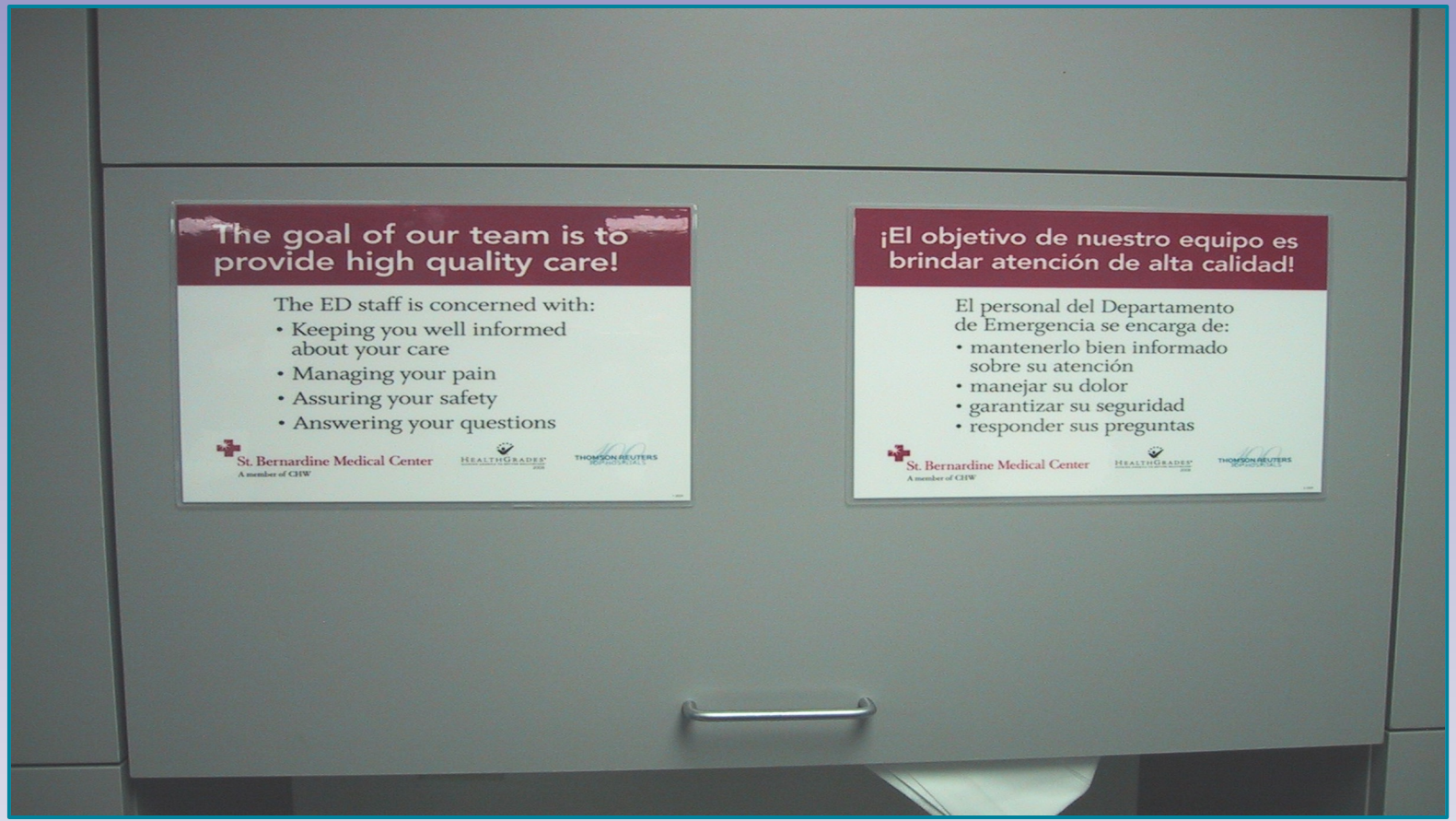

8
7

Transformation

- Collaborative team working together to improve outcomes
- Changed Process – enforced changes with leader rounding
- Build out of triage into old waiting room
- Old triage became internal RAP room
- Old storage area became new stretchers
- Team out front: APP’s, nurses, techs


EMPIECE AQUÍ
BEGIN HERE
SEGURIDAD PÚ
PUBLIC SA
Discharge Window
REGISTRATION
¿Buscando un Médico?
Looking for a Doctor?
INFO
INFORMATION
INFORMACIÓN
WET FLOOR
PLEASE WALK TO THE LEFT
CAUTION
CUIDADO
WET FLOOR


Registrat


The goal of our team is to provide high quality care!
The ED staff is concerned with:
• Keeping you well informed about your care
• Managing your pain
• Assuring your safety
• Answering your questions
St. Bernardine Medical Center
A member of CHW
HEALTHGRADES
THOMSON REUTERS
¡El objetivo de nuestro equipo es brindar atención de alta calidad!
El personal del Departamento de Emergencia se encarga de:
• mantenerlo bien informado sobre su atención
• manejar su dolor
• garantizar su seguridad
• responder sus preguntas
St. Bernardine Medical Center
A member of CHW
HEALTHGRADES
THOMSON REUTERS


Reception


ST. VINCENT
Check-In
Sala de Registración


Ask your nurse ...
FREE
HIV testing
ASK ME
... because it's better to know your HIV status.


T-3

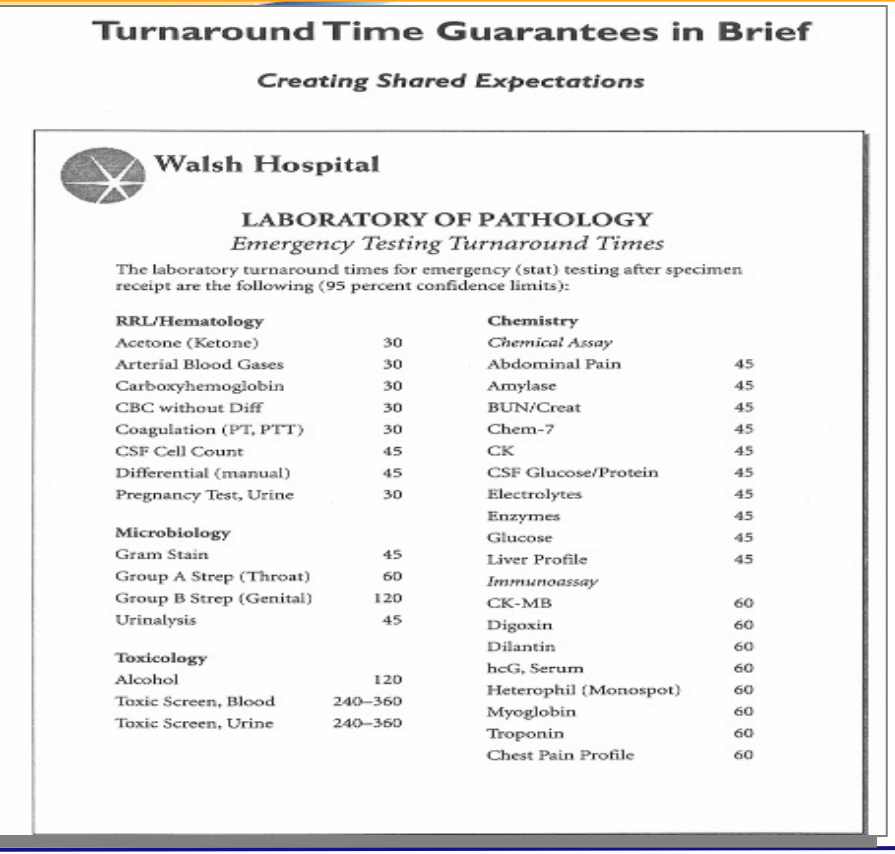

EXIT
ALIDA

The Emergency Department

Metric	Then	Now
Door to Doc/PA	68 mins	26 mins
Patients LWBS	4.6%	1.5%
LOS Pts D/C'd	260 minutes	196 minutes
LOS Pts Admitted	720 mins	524 mins * (-)71 mins
Patient Satisfaction	3rd percentile	31st percentile (11/12 58th)
Core Measures	Near 100%	Near 100%

* With Transition Orders

Systems - While Patients Are In



Turnaround Time Guarantees in Brief

Creating Shared Expectations

Walsh Hospital

LABORATORY OF PATHOLOGY

Emergency Testing Turnaround Times

The laboratory turnaround times for emergency (stat) testing after specimen receipt are the following (95 percent confidence limits):

RRL/Hematology	
Acetone (Ketone)	30
Arterial Blood Gases	30
Carboxyhemoglobin	30
CBC without Diff	30
Coagulation (PT, PTT)	30
CSF Cell Count	45
Differential (manual)	45
Pregnancy Test, Urine	30
Microbiology	
Gram Stain	45
Group A Strep (Throat)	60
Group B Strep (Genital)	120
Urinalysis	45
Toxicology	
Alcohol	120
Toxic Screen, Blood	240–360
Toxic Screen, Urine	240–360
Chemistry	
Chemical Assay	
Abdominal Pain	45
Amylase	45
BUN/Creat	45
Chem-7	45
CK	45
CSF Glucose/Protein	45
Electrolytes	45
Enzymes	45
Glucose	45
Liver Profile	45
Immunoassay	
CK-MB	60
Digoxin	60
Dilantin	60
hcG, Serum	60
Heterophil (Monospot)	60
Myoglobin	60
Troponin	60
Chest Pain Profile	60

- Service goals for Lab, Imaging and Consultants
- All rooms multi-purpose
- Chairs instead of stretchers
- Extenders
- ChargeRN/Physician
- Board Rounds

Systems - Getting Patients Out

- Early Inpatient Discharge
- No delay nurse report
- Weekend Discharges
- “Zero Tolerance” on Hidden beds
- Transition orders
- Full Capacity Protocol

Measurement – “Inpatient Metrics”

- Time physician order to discharge to patient out
- Patient out to call to housekeeping
- Call to housekeeping to bed clean
- Bed clean to assignment of new patient to bed
- Time of bed assignment to new patient in bed

- ☑ Time Order to Patient Out
- ☑ Call to Housekeeping to Room Clean

Key:

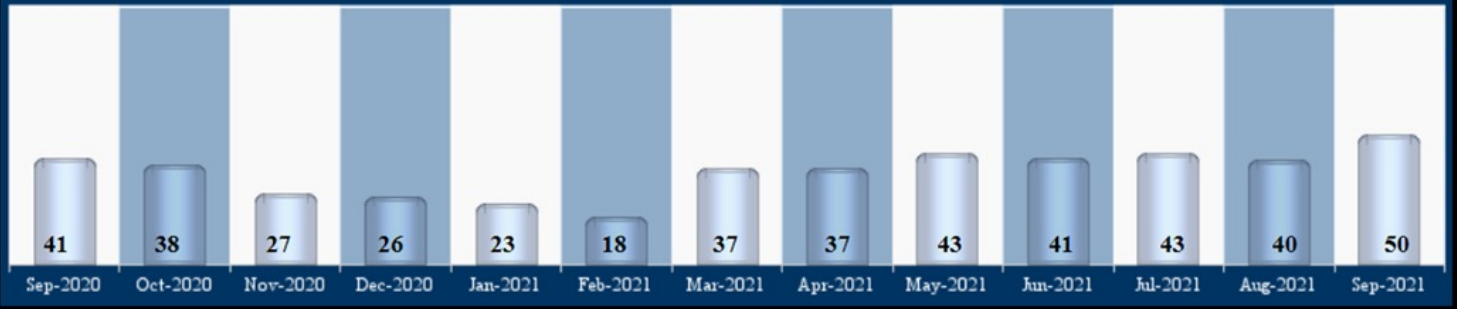
- **Inpt performance indicators**
- **Goals and timeframes**
- **Data collection process**
- **Accountability**

Metric Category	Metric Name (Select to Drill)	Current Month 2021-09	Trend This Month vs Prior 3	3 Month Rolling Average	Same Month Last Year	Metric Limit	Metric Goal	Year over Year To Date % Δ
Admissions	Monthly Admissions (Total)	222		217	213			9%
	Monthly Admissions (Observation)	50		41	41			2%
	% of Observation Admissions	22.5%		19.1%	19.3%			9.9%
	Median ED Decision to Admit to Orders Written	52	▲	41	34	60	45	29%
LOS	Average LOS All Non-Observation Admits (days)	5.1	▼	6.0	3.8	4.5	4.0	27%
	Average LOS Observation Admits Only (hrs)	52.0	▼	59.3	38.0	26.0	23.0	19%
Clinical	30-day Readmit % (All cause)	9.0%	▼	9.9%	10.8%	11.0%	7.0%	6.0%
	Mortality Rate - (%)	0.0%	▼	0.0%	0.0%	1.0%	0.0%	0.3%
Discharges	% of Pt DC Orders Written before 10am (Excl Obs)	42%	▲	31%	45%	35%	45%	17.5%
	% of Pts Discharge by Noon (Excl Obs)	15%	▲	12%	15%	45%	55%	6.2%

Six Month Performance Indicators

Sep 21	Aug 21	Jul 21	Jun 21	May 21	Apr 21
●	●	●	●	●	●
●	●	●	●	●	●
●	●	●	●	●	●
●	●	●	●	●	●
●	●	●	●	●	●
●	●	●	●	●	●
●	●	●	●	●	●
●	●	●	●	●	●
●	●	●	●	●	●
●	●	●	●	●	●

Monthly Admissions (Observation)



Performance YTD vs PYTD

YTD	PYTD
37	36

Variance YTD vs PYTD

Value	%
1	2%

The Inpatient Process

Metric	Then	Now
% Pts D/C by 11 am	31%	66%
D/C order to Pt Departure	168 mins	189 mins 167 mins (3200)
Departure to Room Clean	84 mins	75 mins
ED Admit Request to Orders Received	163 mins	129 mins*
Orders Received to Bed Assignment	280 mins	129 mins
Bed Assign to Pt in Bed	88 mins	69 mins

* Almost Immediate with Transition Orders

Monthly Spreadsheet – Inpatient KPI's

Inpatient KPIs

KPI	Explanation of Metric	Metric Chosen for 2020	Baseline		Jan 2020 Goal	Jan 2020 Actual	Feb 2020 Goal	Feb 2020 Actual
Discharge Orders by 11 am	% of Discharge Orders by 11 am for Inpatient and Observation discharges.	SCIC Physician Governance Decision. Baseline is 2019 Average. 2020 Target Goals chosen based on 2019 average by each facility. Hosptial Throughput Metric.	**30.6%**	**Hosp 1**	34.4%	34.1%	34.4%	39.3%
			20.2%	**Hosp 2**	34.4%	22.2%	34.4%	25.7%
			37.7%	**Hosp 3**	39.6%	41.1%	39.6%	47.4%
			28.9%	**Hosp 4**	34.4%	27.4%	34.4%	23.3%
			43.8%	**Hosp 5**	46.0%	46.3%	46.0%	47.1%
Discharged Patients by 2 pm	% of Admitted Patients that are discharged by 2 pm for Inpatient and Observation discharges.	SCIC Physician Governance Decision. Baseline is 2019 Average. 2020 Target Goals chosen based on 2019 average by each facility. Hospital Throughput Metric.	**45.4%**	**Hosp 1**	47.7%	43.3%	47.7%	47.8%
			32.9%	**Hosp 2**	35.0%	28.9%	35.0%	25.7%
			31.4%	**Hosp 3**	35.0%	31.8%	35.0%	37.9%
			31.1%	**Hosp 4**	35.0%	27.4%	35.0%	31.7%
			32.9%	**Hosp 5**	35.0%	31.8%	35.0%	35.3%

ASAP Emergency Department - KPIs

KPI	Explanation of Metric	Metric Chosen for 2020	Baseline		Jan 2020 Goal	Jan 2020 Actual	Feb 2020 Goal	Feb 2020 Actual
Bed Request to Bed Assigned (minutes)	Time from Bed Request Order for admission or observation requested to time bed is assigned (in minutes)	ASAP Governance. New metric for 2020 and retired Left Without Being Seen Metric. No baseline for 2020. 60 minutes chosen as standard target goal.	NA	Hosp 1	60	19	60	18
			NA	Hosp 2	60	47	60	27
			NA	Hosp 3	60	36	60	25
			NA	Hosp 4	60	141	60	87
			NA	Hosp 5	60	68	60	130
Bed Assigned to patient in Inpatient Bed (minutes)	Time from bed assignment for inpatient or observation bed to time patient is physically in inpatient bed (in minutes).	ASAP Governance. New metric for 2020 and retired Admisssion Time from ED to Inpatient. 120 minutes chosen as standard target goal.	NA	Hosp 1	120	39	120	43
			NA	Hosp 2	120	30	120	44
			NA	Hosp 3	120	57	120	53
			NA	Hosp 4	120	69	120	64
			NA	Hosp 5	120	49	120	52
Arrival to discharge time (in minutes)	Average duration between a patient's arrival and the time the patient is discharged from the ED. Objective is to be **LESS THAN** the target goal	ASAP Governance. Baseline is 2019 Average. All sites chose specific target goals for 2020 based on historic baseline and throughput predictions for 2020.	133	Hosp 1	130	140	130	147
			136	Hosp 2	136	131	136	146
			136	Hosp 3	120	136	120	135
			275	Hosp 4	240	286	240	275
			133	Hosp 5	120	129	120	128
Door to Provider Time	Time from ED checkin to time 1st seen by a Provider (in minutes).	Baseline is 2019 Average. 30 minutes chosen as standard for 2020 at all sites as this is a national standard expectation.	35	Hosp 1	30	34	30	38
			19	Hosp 2	30	15	30	19
			5	Hosp 3	30	5	30	5
			25	Hosp 4	30	25	30	25
			19	Hosp 5	30	17	30	19

Individual Physician Profiles

- If you do not measure by the individual, no one will ever admit that their practice is not A+ the best . . .
- The excuses are:
  - My patients are different.
  - The data must be wrong.
  - It's not statistically valid.
  - . . .

Variation in Clinical Practice is Rampant

IMAGING FOR THE CLINICIAN SPECIAL SECTION
CLINICAL RESEARCH STUDY
Robert G. Stern, MD, Section Editor

THE AMERICAN JOURNAL of MEDICINE®

Variation in Use of Head Computed Tomography by Emergency Physicians

[c,e] Richard D. Zane, MD,[a,c,e]
[e] Schneider, MD,[a,c] Richard Hanson,[a,b]
MPH[a,b,e]
[c]Emergency Medicine, and [d]Center for Surgery and Public
dical School, Boston, Mass.

Head CT examinations were ordered in 8.9% of emergency department visits

- Two-fold variation in overall head CT ordering (6.5–13.5%),
- Three-fold variation in head CT ordering for atraumatic headache (21.2–60.1%).

dicine (2012)

Summary

- What reserve we had is gone – efficient practice is essential.
- Careful resource utilization with appropriate cost containment is crucial to success.
- Consistency is crucial . . . Measurement is a must, individual as well as group.
- Use of technology is an imperative.

Questions?

Thank you.

Jay Kaplan, MD, FACEP
jaykaplanmd@gmail.com