



Urgent Matters

An RWJF national program

SUMMARY

Urgent Matters was a national program of the Robert Wood Johnson Foundation (RWJF) that aimed to relieve emergency department overcrowding, improve patient care and increase patient satisfaction.

The program also sought to use the example of emergency departments to help communities understand the interdependence between the health care safety net—of which emergency departments are a key component—and the rest of the health care delivery system.

The program operated in two phases.

- Under Phase I, 10 hospitals received grants and technical assistance to test changes in the emergency room and throughout the hospital to improve patient flow. Each hospital also partnered with a local agency in its community to prepare a report that assessed the capacity of the local health care safety net.
- Under Phase II, the program shifted focus to communicating findings about emergency room best practices. National program staff gathered information about best practices to improve patient flow in hospital emergency departments and served as a clearinghouse for this information. The program's national staff also worked with medical organizations and the federal government to help broadly disseminate best practices.

Key Results

- All *Urgent Matters* hospitals reduced patient wait times in several areas within the emergency department.
- The 10 hospitals and their community partners produced [reports](#) detailing the state of the safety nets in their communities.
- *Urgent Matters* national program staff compiled a draft toolkit of strategies to achieve best practices for improving patient flow both in an emergency room and throughout a hospital. The toolkit—the first ever, according to national program staff—includes a brief description of each strategy, access to other tools and the demographics of the

hospital in which the strategy was field-tested. In November 2008, the federal Agency for Healthcare Research and Quality (AHRQ) began a process to test, refine and validate many of the best practices and tools in the toolkit.

In February 2011 RWJF and *Urgent Matters* made an [updated toolkit](#) available to the public. This toolkit currently contains 55 strategies with 95 associated tools. Each strategy includes information on the hospital where the strategy was piloted, associated tools, and a description of the strategy implementation and outcomes.

- In 2005, the [Joint Commission](#), based in Chicago, which accredits hospitals, added a new requirement for hospital accreditation prompted in part by the work of *Urgent Matters*, according to National Program Director Bruce Siegel, M.D., M.P.H. The standard requires that hospital leaders develop and implement plans to identify and lessen impediments to efficient patient flow throughout the hospital.

Program Management

RWJF set up a national program office to manage the program at the George Washington University School of Public Health and Health Services, based in Washington. Siegel directed the program.

Funding

The RWJF Board of Trustees authorized the program in July 2002. The Trustees reauthorized the program for the second phase in May 2004. The total authorizations were for up to \$6.48 million. RWJF supported the program with grants totaling \$5,118,461 between September 2002 and February 2008.

THE PROBLEM

People who lack health insurance or are underinsured often depend on the safety net system—that is, those health care providers (e.g., public hospitals, publically funded clinics and the emergency departments of all hospitals) that care for everyone regardless of ability to pay. In the late 1990s and early 2000s, growing numbers of people without the ability to pay were seeking care through safety net providers, placing those institutions increasingly under strain.

Nowhere was this more evident than in hospital emergency departments, which often serve as the place of last resort for people requiring health care. Emergency departments are often the only "open door" in a community's health care safety net and the only provider of essential services such as burn and trauma care. In addition, the nation's ability to respond to bioterrorism or events involving mass casualties requires hospital and emergency department capacity in every community.

Many cities during this time were reporting dramatic increases in emergency department wait times. What's more, emergency departments were becoming so crowded with patients that many frequently closed their doors to additional patients, diverting them to other hospitals until they caught up treating those patients already waiting for care.

Specifically,

- Emergency department visits increased nationwide by 14 percent from 1997 through 2000, while the number of emergency departments decreased, according to a 2002 report in the [National Hospital Ambulatory Medical Care Survey](#) from the National Center for Health Statistics, part of the federal Department of Health and Human Services.
- An April 2002 national survey for the American Hospital Association revealed that 79 percent of all urban hospitals reported being "at or over" operating capacity. The proportion rose to 87 percent for Level I (the most advanced level) trauma centers.

Many factors contributed to this phenomenon, including:

- Increased demand, in particular from rising numbers of uninsured people.
- Institutional factors, including difficulties in recruiting quality professional staff. If hospitals cannot recruit personnel such as neurologists or X-ray or laboratory technicians, then patients—including emergency room patients—may endure long waits for consultations or test results.

These trends were troubling, given the unique role of the emergency department in the health care system.

CONTEXT

Early Days: Emergency Medical Response System

Since its earliest days, the Robert Wood Johnson Foundation (RWJF) has supported efforts to strengthen emergency medicine in the United States.

RWJF's initial work in emergency care related to improving the emergency response system in the United States. RWJF's first national multisite demonstration program was the Emergency Medical Services (EMS) program, which ran from 1973 to 1978. EMS has been recognized for forming the basis for the 911 emergency response system. See the RWJF Anthology, Volume VIII, [Chapter 10](#), on the program.

Turning Attention to the Quality of Emergency Department Care

Beginning in the late 1980s, RWJF's interest in emergency medicine shifted to the connections among emergency care, the safety net and access to primary care. RWJF and

its partners were particularly interested in the extent to which people with inadequate access to primary care use emergency rooms as an inappropriate substitute.

RWJF's work followed three general tactics:

- Health services research on the link between emergency care and the safety net.
- New models of care to reduce emergency department use.
- Public education to get the word out about the crisis in emergency care.

A grant in 2002 to the [Health Research and Educational Trust](#), with offices in Chicago and Washington (ID# 042634), funded a study that examined:

- The causes of emergency department overcrowding.
- The characteristics of hospitals and surrounding communities associated with high degrees of emergency department overcrowding.
- How hospitals are responding to excess demand for emergency department services.

That research informed the development of technical assistance provided through *Urgent Matters*, the program described in this report.

PROGRAM DESIGN

Urgent Matters was a national program that aimed to help relieve emergency department overcrowding, improve patient care and increase patient satisfaction.

The program also intended to use the example of emergency departments to help communities understand the interdependence between the health care safety net—of which emergency departments are a key component—and the rest of the health care delivery system.

In its original design, *Urgent Matters* had three goals:

- Increase community awareness of the importance and fragility of the health care delivery system safety net.
- Significantly reduce wait and board times in emergency departments of hospitals receiving program funding.
- Produce one or more replicable models of emergency department overcrowding reduction.

Once RWJF authorized funding for *Urgent Matters*, program staff quickly contracted (Grant ID# 046486) with Bruce Siegel, M.D., M.P.H., whom RWJF had selected to direct

the national program office, to jumpstart program implementation by devising an application and site selection process and to continue to refine the program's design.

Siegel proposed several essential design elements for the program, among them:

- Involvement from the top-level leadership of participating hospitals.
- Measureable goals for participating hospitals.
- Collaborative learning among the hospitals.

Siegel and RWJF staff originally envisioned only one phase for the program. From 2004 to 2008, however, RWJF provided funding for a second phase to enable the national program office to:

- Disseminate broadly and strategically the findings from the first program phase.
- Package the tools and the learning collaborative concept developed under the first phase into marketable products.

THE PROGRAM

The program operated in two phases. Phase I incorporated the original program design:

- Helping participating hospitals identify and test ways to reduce overcrowding and improve patient flow in the emergency department.
- Assessing the health care safety net in the communities of participating hospitals.

Under Phase II, the program shifted focus to communicating findings about emergency room best practices. National program staff gathered information about best practices to improve patient flow in hospital emergency departments and served as a clearinghouse for this information. The program's national staff also worked with medical organizations and the federal government to help broadly disseminate best practices.

National Program Office

Siegel at the George Washington University School of Public Health and Health Services in the District of Columbia directed the program. Marcia Wilson was the deputy director.

National Advisory Committee

The national program office recruited a national advisory committee that included emergency department physicians, hospital chief executive officers and officials from the federal Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services. See [Appendix 1](#) for list of national advisory committee members.

Phase I

Phase I took place from September 2002 to April 2004.

Site Selection

Only hospitals with a Level I or Level II trauma designation could apply for grants. These hospitals have the busiest emergency departments, and they were most likely to need to divert incoming ambulances to other hospital emergency departments.

The national program office received 287 Letters of Intent from hospitals and invited 30 full applications. Program staff and advisory committee members chose 10 hospitals to participate based on several criteria, including:

- Evidence of emergency room crowding.
- Emergency department volume and the hospital's market share within the community.
- Demonstrated commitment of hospital leadership and staff to making changes to improve hospital services.

The 10 hospitals, all of which served as important safety net providers within their communities, were:

- Boston Medical Center, Boston
- BryanLGH Medical Center, Lincoln, Neb.
- Elmhurst Hospital Center, Queens, N.Y.
- Grady Health System, Atlanta
- Henry Ford Health System, Detroit
- Inova Health System, Fairfax, Va.
- Regional Medical Center at Memphis, Memphis, Tenn.
- St. Joseph's Hospital and Medical Center, Phoenix
- University Health System, San Antonio
- University of California at San Diego School of Medicine, La Jolla, Calif.

See [Appendix 2](#) for more details on the participating hospitals.

A Learning Network to Improve Emergency Room Patient Flow

RWJF designed the program to create an intimate learning community of the 10 hospitals. The learning network worked for one year (May 2003 to April 2004) to develop and implement best practices in reducing emergency department overcrowding.

All the participating hospitals were to test small changes in their patient flow processes, make revisions and try again in a quality improvement technique called *rapid-cycle change*.

This is a quality-improvement method that identifies, implements and measures changes made to improve a process or a system. At the onset, the team sets an outcome measure based on the system's goals. Improvement occurs through small, rapid PDSA (Plan, Do, Study, Act) cycles to advance practice change.

This model requires:

- Targeting a specific area to change.
- Planning changes on the basis of sound science, theory and evidence.
- Piloting several changes with small patient groups.
- Measuring the effects of changes.
- Acting according to the data.

The fundamental concept of rapid-cycle improvement is that health care processes—once defined, in place and in effect—should be improved continually by instituting a constant cycle of innovations or improvements. The approach was designed to allow organizations to build quickly on successful results, achieve organizational buy-in and accelerate change.

Each participating hospital created a team that included staff from the emergency department, other inpatient departments and the administration. Teams were interdisciplinary because the ability to move patients in an efficient and timely manner relies on the interactions of many different units throughout a hospital.

The national program office provided technical assistance over the course of the year, including:

- Site visits by advisors who were experts in quality improvement.
- Two conferences with all participating hospitals, including each hospital's CEO, to discuss expectations of the program, learn quality improvement techniques and share findings about what did and did not work.
- Monthly conference calls with all participating hospitals on selected topics, including strategies that worked to reduce emergency department crowding and ways to encourage staff to participate in making changes in the emergency department.
- One-on-one monthly calls between site staff and advisors.
- Access to a password-protected website.

Each hospital received an additional \$25,000 to pay for staff time and travel to conferences.

Developing a Set of Measures to Improve Emergency Department Performance

By breaking down the emergency room process into smaller steps and measuring them, RWJF and national program staff believed that hospitals would be able to see where the bottlenecks were and test ways to fix them. The national program office designed 17 measures to analyze the total amount of time a patient spent in an emergency room encounter, from the patient's arrival at the emergency room to his or her admission to the hospital or discharge from the emergency room.

The measures captured information such as:

- How long it took for patients to get seen by emergency room staff once they checked in at an emergency department.
- How long it took from the time of triage—the early stage of an emergency room visit when emergency room staff determines the urgency of a patient's condition—to the time the patient is brought to a bed in the emergency department.

The full set of measures is in the following chart:

FACTOR	INDICATOR	REPORTING INTERVAL	
I. Clinical Process (choose one)	1. Time to heart treatment—patient arrival at the Emergency Department (ED) => thrombolytic medication is administered or a vessel is opened.	Monthly	
	2. Time to pain management (fractures/dislocations)— time of arrival => first administration of pain management, meds or ice packs.		
II. Inpatient Flow	1. Time from inpatient bed assignment to bed placement—inpatient (IP) bed available and assigned => patient arrives in unit and is placed in bed.	Weekly	
	2. Time of day of discharge—average time of day that inpatients are discharged.*		
	3. Bed turnaround time—time that a bed becomes empty => time that the bed is reported as cleaned and available for use by a new patient.		
III. ED Throughput	1. Total ED throughput time—patient's arrival => patient disposition.**	Weekly	
	2. <i>By treatment path:</i> Admitted Fast Track Other ED Discharged		a. Time from arrival to bed placement—patient arrival in the ED => time the patient is first placed in a bed for exam and treatment.
			b. Time from bed placement to examination—time a patient is first placed in a bed => time the patient is first seen by a physician.

		c. Time from disposition decision to departure—time physician issues a discharge or admit order => time patient has left the ED.	
IV. Other ED	1. Hours on diversion—if hospitals were allowed to go on diversion, total number of hours on diversion.		Monthly
	2. Percentage incomplete treatment—percentage of patients who leave prior to completion of treatment (leave without being seen, against medical advice or for any other reason before medical treatment is completed).		Monthly
	3. Patient satisfaction—use existing measures of patient satisfaction.		Monthly

* Participating hospitals had to report results based on these measures each week or month (depending on the measure) on the password-protected website.

** Hospitals also could track their progress via the website to determine which strategies had been most effective in improving flow or reducing crowding.

Each hospital could also see how the other hospitals were doing through the website. This created some healthy competition among participants, said National Program Director Siegel.

Extra Funding for Four Demonstration Sites

At the same time that the national advisory committee selected the 10 hospitals to participate in the learning network, the committee chose four among the 10 to receive additional \$250,000 grants to develop, implement and evaluate a specific program of their own design. The committee chose the four hospitals based on the following criteria:

- Feasibility, degree of innovation and expected impact of the proposed demonstration.
- Inclusion and support of other partners appropriate to the proposed demonstration, such as mental health providers, home health care providers, specialty physician groups and others.
- Sustainability of the interventions.

The four hospitals and the innovations they tested were:

- **Boston Medical Center.** Spreading out the elective surgery schedule over several days instead of batching the surgeries on one day to lessen backup on inpatient beds on elective surgery days.
- **Grady Health System.** Creating a new seven-bed Care Management Unit designed to provide both clinical and case management services to patients with a core group of often chronic conditions, including asthma, chest pain, heart failure and hyperglycemia, who often present to the emergency room for these conditions. The goals were to reduce hospital admissions through better management of these conditions and to increase utilization of community resources for patient care.

- **Inova Fairfax Hospital.** Reducing emergency department wait times and increasing patient satisfaction by deploying physician and nurse teams to provide care to patients at triage when possible.
- **Regional Medical Center at Memphis.** Determining the feasibility and applicability of using radio frequency identification tags to track trauma patients as they moved through each step of their emergency room treatment and to identify where bottlenecks were occurring. The tags contained small integrated circuits with attached antennas, and each tag announced its location whenever it was near a tag reader.

Community Safety Net Assessments

Each hospital also received \$25,000 to pay for a community partner to develop a safety net assessment. These assessments contained:

- A description of the demographic characteristics of the community and the structure and financing of its safety net services.
- Results from discussions with groups of local residents as well as interviews with key stakeholders and safety net providers.
- Analysis of data from residents' use of the emergency department at the hospital participating in *Urgent Matters*.

Phase II

Phase II took place from May 2004 to February 2008.

Becoming a Resource Clearinghouse

In this phase, the national program office focused on becoming a communications clearinghouse for promising strategies on reducing emergency department crowding.

"We became much more focused on being a clearinghouse of innovation—getting the lessons of *Urgent Matters* out, mining the industry for lessons and holding conferences," Siegel said in an interview. "[The program became] more of an educational resource and less of an experiment."

As part of the dissemination effort, the national program office compiled a preliminary toolkit of best practices for improving emergency room patient flow. To create the toolkit, national program staff members combed through news reports and conference proceedings, conducted literature searches and interviewed hospital leaders and emergency room doctors to supplement information that the *Urgent Matters* participating hospitals were producing.

Activities in Phase II focused on highlighting the best practices in the toolkit through:

- *Educational activities*, including Web seminars and regional conferences.
- *Working with key stakeholders*, including the Joint Commission and the Centers for Medicare & Medicaid Services.
- *Presenting and publishing papers* on the issue of emergency department crowding for academic and professional audiences.

The aim was to reach more hospitals with tools developed under the program and elsewhere.

Exploring Options for a Second, Fee-Based Learning Network

Also during this phase, at the request of RWJF, the national program office staff explored options that might lead to *Urgent Matters* becoming self-sustaining by charging user fees for participating in a learning network.

During this phase, *Urgent Matters* put out a call for applications in which each hospital would pay \$85,000 as a participation fee. Just three hospitals agreed to participate, and the idea of a second learning network was dropped.

Challenges

Difficulties in Charting New Paths

Some site staff discovered to their surprise that they were charting new territory in undertaking to find ways to reduce emergency room overcrowding. Adding to that stress was the learning network's tight time frame.

"When we read the grant, there was an impression that there was [already] a tool box," said David Hnatow, director of the emergency department at University Health System in San Antonio. "Then we realized that the tool box was empty. We were supposed to invent the tools."

Despite the sometimes frustrating lack of resources available from the national program office—or anywhere else—Hnatow found it valuable to have consultants come to the hospital and provide assistance in understanding how to test and implement changes quickly.

Resistance to Change

National Program Director Siegel reported that it was difficult to persuade hospital officials that they could find solutions to what seemed to be an intractable problem.

Neils Ratlov, M.D., director of clinical operations in the emergency department at Boston Medical Center, echoed Siegel's sentiments and said that it was easier to get hospital staff

on board when the project started to show that it was making progress in reducing patient wait times.

Hospitals' Reluctance to Pay High Fees for Learning Networks

One of the objectives of Phase II was to determine whether hospitals would pay to be part of a learning community that the original 10 hospitals had participated in for free in Phase I. The goal was to make the learning networks sustainable.

Although national program office staff members had talked to some colleagues in the field about this idea, they had not talked to users or potential customers about whether they would be willing to pay to participate in such a learning community. It proved difficult to attract much interest in paying to participate in the proposed network.

OVERALL PROGRAM RESULTS

Phase I

- **All *Urgent Matters* hospitals reduced patient wait times in several areas within the emergency department.** Examples of the strategies they used include:
 - Creating a "Bed Czar," or patient flow manager. This person was responsible for ensuring the timely transfer of emergency department patients to assigned inpatient beds.
 - Doing a preliminary designation of certain patients for early discharge the following day to make their beds available earlier in the day.
 - Replacing the traditional "push" system of asking inpatient units for available beds with a "pull" system in which the inpatient units played an active role in pulling patients from the emergency department into available inpatient beds.

"The *Urgent Matters* experience showed that hospitals can dramatically improve patient flow and decompress their emergency department without investing significant financial resources," National Program Director Siegel wrote in an April 2008 report to RWJF.

Urgent Matters staff wrote *Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments*, which documented the projects and their lessons learned.

Urgent Matters staff wrote a second report, commissioned by the National Association of Public Hospitals and Health Systems, *Perfecting Patient Flow: America's Safety Net Hospitals and Emergency Department Crowding*, describing practical approaches to reducing emergency department overcrowding in three of the demonstration hospitals.

- **Eight of the hospitals also made changes on the inpatient side of the hospital that resulted in reduced crowding in the emergency department.** For example, University Hospital in San Antonio reduced its average bed turnaround time—the time from when a bed in an inpatient unit becomes empty to the time the bed is reported as clean and available—from more than 160 minutes to approximately 40 minutes. That meant that emergency department staff was able to move patients out of the emergency room to inpatient beds much more quickly, avoiding backups.
- **The four hospitals that received the \$250,000 demonstration grants undertook more complex changes that required a significant investment of resources, according to the national program office.** Among these hospitals' achievements were the following:

- ***Boston Medical Center*** reduced the average time a patient spent in the emergency department from 4.8 hours to 3.8 hours (a 17 percent decrease); reduced the average bed turnaround time from 120 minutes to 66 minutes (a 45 percent decrease); reduced by 40 percent the amount of time that the hospital was unable to accept ambulances with emergency patients and, therefore, was forced to divert them to other emergency rooms; and increased inpatient volume by 4 percent.

Under the demonstration, to reduce backups on elective surgery days, vascular surgeons agreed to schedule fewer elective surgeries on those traditional days in exchange for being able to schedule more elective surgeries overall during a week. The hospital spread the initiative to cardiac and other surgical specialties.

Another strategy was to create two zones in the nonacute section of the emergency department. Nurses were then assigned to only one of the zones, reducing the time they spent moving around.

- ***Grady Health System*** in Atlanta reduced from 7 hours to 5.25 hours the amount of time from patients' arrival at the emergency department until they were released or admitted to an inpatient unit.

Under the demonstration, the Care Management Unit that Grady created for the project improved chronic care patients' access to primary care (all received doctor's appointments within 48 to 72 hours of their visit to the emergency room) and decreased the number of short-stay admissions, decreasing costs for those patients and increasing their satisfaction.

- ***Inova Fairfax Hospital*** in Fairfax, Va., reduced the number of hours during which it was forced to divert incoming emergency patients to other hospitals' emergency departments from 136 hours to 21 hours per month.

Under the demonstration, the triage team reduced the percentage of patients who left the emergency room without being treated by a physician, reduced waits and had an impact on diversions to other hospitals.

Another strategy the hospital tested—moving emergency department patients to inpatient units whether or not a bed was available—was less feasible and had less impact, according to Siegel.

- ***The Regional Medical Center at Memphis*** reduced the average amount of time from the assignment of an inpatient unit bed to an emergency department patient to when the patient actually got to the bed from more than 1,000 minutes to less than 60 minutes.

Under the demonstration, the hospital used several strategies, including color-coding patients' records when they arrived in the emergency room according to the priority in which they needed to be seen.

The hospital also created a discharge resource room where patients awaited arrival of family members and received post-discharge education and information.

Additionally, the hospital determined that the tracking technology it used to identify bottlenecks was both technically and financially feasible.

- **Each of the 10 hospitals and their community partners produced 30- to 40-page reports detailing the state of the safety nets in their communities.** "The composite findings from all 10 sites provided an informed picture of the state of the safety net across the nation," wrote Siegel in an April 2008 report to RWJF.

Among the community agencies that helped produce the reports were:

- Community Health Endowment of Lincoln (Nebraska).
- Community Health Improvement Partners (San Diego).
- Voices of Detroit Initiative.

Nine of the 10 community partners scheduled at least one community event to announce the report findings with coverage by the local press. Anywhere from 30 to 300 people attended these meetings.

At many sites, elected officials, including the mayor and other key stakeholders from organizations such as the local chamber of commerce, attended these presentations.

- **The national program office produced a report *Walking a Tightrope The State of the Safety Net in 10 U.S. Communities* that summarized the assessment findings.**

Phase II

- ***Urgent Matters* national program staff compiled a draft toolkit of strategies to achieve best practices for improving patient flow both in an emergency room and throughout a hospital.** The draft toolkit—the first ever, according to national program staff—included a brief description of each strategy, access to other tools and the demographics of the hospital in which the strategy was field-tested.

As of April 2008, the toolkit contained 41 best practices with more than 65 associated tools.

Ultimately, this toolkit was not made available to the public. In November 2008, the federal Agency for Healthcare Research and Quality (AHRQ) began a process to test, refine and validate many of the best practices and tools in the toolkit.

See [Afterward](#) for more details about a process to test and refine the tools and strategies in the toolkit.

- ***Urgent Matters* program staff helped the [Joint Commission](#)—which accredits hospitals—develop a case study on improving patient flow.** Commission surveyors were to use the case study to determine whether leaders of hospitals seeking accreditation were developing and implementing plans to identify and lessen impediments to efficient patient flow.

The Joint Commission added the standard relating to improving patient flow in 2005. It began implementing the standard in January 2008 when commission surveyors began identifying problems with patient flow in hospitals and examining hospital efforts to address them.

- ***Urgent Matters* national program staff acted as advisors to state hospital associations, national organizations and the federal government about reducing emergency department crowding and improving patient flow.**

- In February 2006, *Urgent Matters* staff attended a meeting in Atlanta convened by the [Emergency Department Benchmarking Alliance](#) to discuss and develop performance measures for emergency departments. The alliance, based in Dayton, Ohio, is an organization of emergency department physicians that works to identify, test and implement best practices in emergency departments.

Some 19 alliance members participated along with representatives from federal agencies, including the Centers for Medicare & Medicaid Services (CMS) and AHRQ. The alliance circulated the resulting Consensus Statement among the emergency medicine community for comment and posted it on the *Urgent Matters* website.

- In July 2006, CMS convened a meeting on patient flow performance measures in which *Urgent Matters* staff members participated. The meeting culminated in the creation of a technical expert panel charged with developing and recommending emergency department performance measures.

National program staff members participated in the panel that the Oklahoma Quality Improvement Organization convened, which began its work in April 2007. The panel and CMS recommended seven measures.

See [Afterward](#) for more details about a process to test and refine the measures.

As of November 2008, the panel was still standing, although not active, according to Siegel.

Communications

Phase I

Urgent Matters staff created a [website](#) early in the program on which staff posted—over the course of the program—reports on program findings and other resources and outside links to help hospitals deal with emergency department crowding.

Urgent Matters also launched an e-newsletter to highlight the work of the collaborative hospitals as well as to share perspectives from industry leaders. The e-newsletter provided a forum for communicating with emergency room physicians, nurses and administrators—as well as others interested in issues of emergency room crowding and patient flow.

National program office staff published five issues of the e-newsletter during Phase I.

Phase II

Most communications activities took place once the learning collaborative finished. During Phase II of the program, the national program office focused intensively on disseminating program findings, as follows:

Meetings and Seminars

The national program office hosted a national meeting, three regional conferences and seven Web-based seminars (called Webinars) in Phase II:

- The national meeting was the final gathering of the *Urgent Matters* learning network. The national program office invited other hospitals to participate in this meeting to learn about participating hospitals' results, including their community safety net assessments. Outside experts also made presentations to provide a "big picture" perspective on how emergency department crowding affects the health care system.
- The national program office also hosted three regional meetings that participants paid to attend. More than 275 people participated in at least one of these events. The conferences focused on approaches by hospitals and organizations across the country to reduce emergency department crowding. Participants included representatives of national organizations such as the National Association of Public Hospitals, the Joint Commission and the American College of Emergency Physicians.
- The national program office hosted seven Webinars, each featuring national experts on managing emergency department crowding and patient flow. More than 2,000 people participated in at least one of these seminars.

Electronic Communications

The national program office developed a list of more than 4,100 subscribers to its e-newsletter and published 17 additional issues during Phase II.

The national program office also used the *Urgent Matters* website to disseminate findings from the program. For example, staff posted on the site:

- *Bursting at the Seams: Improving Patient Flow to Help America's Hospitals*, which documented the projects and their lessons learned.
- *Perfecting Patient Flow: America's Safety Net Hospitals and Emergency Department Crowding*, which described practical approaches to reducing emergency department overcrowding in three of the demonstration hospitals.
- *Walking a Tightrope: The State of the Safety Net in 10 U.S. Communities*, which summarized the safety net assessment findings.
- The safety net assessment report on each of the 10 communities, for example:
 - *An Assessment of the Safety Net in Lincoln, Nebraska.*
 - *An Assessment of the Safety Net in San Diego, California.*
 - *An Assessment of the Safety Net in Fairfax County, Virginia.*

The website received 2.4 million hits and averaged 1,719 hits a day from May 2004 to the close of the program in February 2008.

Other Scholarly and Professional Venues

The national program office published articles about improving patient flow in peer-reviewed journals, trade journals and association e-newsletters.

See the [Bibliography](#) for details on all this communications work.

LESSONS LEARNED

1. **Recognize that emergency department crowding is a hospital-wide problem, not simply an emergency department problem.** If hospitals do not view emergency department crowding as a hospital-wide issue, then any efforts they make toward changes will fail or have limited success. (Program Director)
2. **Build multidisciplinary, hospital-wide teams to implement and oversee change.** These teams must include representation not only from the emergency department, but also from inpatient services and other support functions that are essential to the change process. (Program Director)

3. **Seek out a "champion" to lead efforts to make change.** If efforts to make changes in a hospital are to succeed, one well-respected individual in a leadership position must serve as the champion of change. That means the individual will sell the importance of change to the medical staff and executive management and continue to advocate for change. (Program Director)
4. **Ensure management's support.** Reducing emergency department congestion and improving patient flow must be priorities at the highest level of the hospital. Hospital chief executive officers should be vocal in their support for these initiatives. If hospital leadership walks away from efforts to improve patient flow, chances for success will drop dramatically. (Program Director)
5. **Use formal quality improvement methods to reduce the risks of change.** Using rapid-cycle change, hospital staff can bypass political and financial hurdles by testing small changes. This approach also offers flexibility and allows hospitals to initiate change with minimal financial risk. (Program Director)
6. **Commit to rigorous metrics to drive important decision-making and increase executive support.** Data collection is an absolute requirement, although it is a significant challenge for any hospitals that do not have data collection methods in place. (Program Director)
7. **Use collaboration and healthy competition to enhance performance improvement.** Sharing results about key performance indicators, between departments and with other institutions, motivates hospital staff and administration to perform at high levels in order to be recognized as leaders. (Program Director)
8. **Disseminate best practices of hospitals that achieve change to encourage people who see the problem of emergency room overcrowding as beyond their control.** "It doesn't have to be this way," said National Program Director Siegel. "Hospitals in the learning network made dramatic improvements in flow. That was contrary to popular wisdom," he said.
9. **To influence change in a hospital, insist that the chief executive officer sign on and participate in the program.** In this case, not only did participating hospitals have to get their CEO's approval, but also the CEO had to travel to *Urgent Matters* meetings and participate. By requiring that level of involvement, the national program staff ensured that CEOs would back the program and the changes it effected. (Program Director)
10. **Provide face-to-face meetings for hospital executives and other staff so that they can meet counterparts doing similar work.** Although physicians may not need or have the time to travel to meetings, the national program staff learned that hospital staff and executives are hungry to meet with their colleagues and exchange ideas about how to solve common problems. (Program Director)

11. **Understand who makes the decision to pay for a service and approach that person before making firm plans to offer the service.** The national program office did some informal research among colleagues in the field about charging fees to participate in a learning network but did not ask the target audience—hospital officials—if they would pay for the activity. Most would not. (Program Director)

AFTERWARD

Testing and Disseminating Ways to Reduce Emergency Department Crowding

In early 2008, AHRQ announced its intention to use its ACTION Partnership to test the seven emergency department performance measures that the technical advisory panel proposed as well as strategies to improve emergency department patient flow. ACTION (Accelerating Change and Transformation in Organizations and Networks) promotes innovation in health care delivery. It includes 15 large partnerships to test interventions and to ensure that research results get incorporated into health care system practice. Under the plan, Siegel and his colleagues at George Washington University created the *Urgent Matters* Learning Network II (LN II). LN II has developed hospital ED performance measures with the aim of improving quality. Six participating hospitals nationwide have worked together over an 18-month period to identify, develop and implement strategies to do this while improving patient flow and reducing ED crowding. The six participating hospitals are:

- Westmoreland Hospital, Greensburg, Pa.
- St. Francis Hospital, Indianapolis
- Hahnemann University Hospital, Philadelphia
- Thomas Jefferson University Hospital, Philadelphia
- Stony Brook University Medical Center, Stony Brook, N.Y.
- Good Samaritan Hospital Medical Center, Suffolk County, N.Y.

The participating hospitals have used tools and strategies from the *Urgent Matters* toolkit and others. According to Siegel, the learning network began its work in September 2008.

As detailed in a February 2010 *Issue Brief* from RWJF, *Urgent Matters* LN II has three key goals:

1. Rigorously evaluate the implementation of strategies for improving patient flow and reducing ED crowding within the context of a hospital learning network.
2. Advance the development of standard performance measurement in the ED.

3. Promote the spread of promising practices to a wider audience and variety of hospitals.

LN II hospitals have focused on advancing the development of quality improvement performance metrics in EDs by field-testing and evaluating ED performance measures for the first time. This is essential, according to the Issue Brief, because "unlike other clinical areas, such as cardiac care, the field of emergency care currently lacks a uniform set of metrics which inform providers, administrators, and consumers about the status of their ED's care. Without meaningful ED performance measures, it is impossible to gauge the impact of new interventions, strategies, or tools. Standardized performance measures create common terminology and provide an opportunity for comparison and improvement."

Hospitals have used seven select performance measures, three of which are [National Quality Forum](#) (NQF)-endorsed and have been considered by the U.S. Centers for Medicare & Medicaid Services (CMS) for inclusion in the public reporting system in 2012. CMS reports measures through its Hospital Compare [website](#). The National Quality Forum is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting.

Lessons learned from the 18-month *Urgent Matters* initiative will be made available to hospitals nationwide through program products, presentations at national conferences, journal publications, and through the AHA network and publications.

In April 2010, RWJF held a policy forum in Washington to share what has been learned in *Urgent Matters*. The forum, now available via [webcast](#), featured the perspectives and learning of the participating hospitals, project leaders and a select group of nationally recognized leaders in emergency medicine who were invited to attend.

RWJF also released an [Issue Brief](#), which examines the program's large-scale potential impact on the nascent field of ED performance benchmarks, improving consumer decision-making and stimulating the sharing of quality improvement strategies that work.

In February 2011, *Urgent Matters* LN II released its final report, *Following the Leader*. This report details the success of and lessons learned by the *Urgent Matters* LN II hospitals in meeting their goals, presenting case studies of the six participating hospitals' use of different strategies to improve flow in their facilities.

Urgent Matters and RWJF also released the [updated toolkit](#). It contains 55 strategies with 95 associated tools. Each strategy includes information on the hospital where the strategy was piloted, associated tools, and a description of the strategy implementation and outcomes.

Strategies are organized into five categories:

- Input
- Throughput
- Output
- Communications/Information Technology (IT)
- Scheduling/Staffing.

Other RWJF National Programs Using the Collaborative Learning Model

RWJF developed two other national programs based on the *Urgent Matters* model of collaborative learning. To manage the programs, RWJF funded George Washington University School of Public Health and Health Services to act as the national program office for both programs.

The programs were:

- *Expecting Success: Excellence in Cardiac Care*, an initiative aimed at improving cardiac care for racial and ethnic minority populations in the United States.

Using a collaborative learning network of 10 hospitals around the country, the initiative developed and disseminated quality improvement strategies and models and resources to improve cardiac care for underserved minority populations in a variety of clinical settings. The program began in November 2004 and ended in April 2009. Siegel was the program director and Wilson the deputy director. See [Program Results Report](#) for more information.

- *Speaking Together: National Language Services Network*, a national program aimed at improving the quality and availability of health care language services for patients with limited English proficiency.

Speaking Together integrated quality improvement with language services and brought together 10 hospitals to pilot new performance measures and test techniques for reducing health care disparities associated with language barriers. The program began in November 2005 and ended in September 2009. Marcia Regenstein, Ph.D., was the program director. See [Program Results Report](#) for more information.

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APPENDIX 1

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APPENDIX 2

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