**Summary:**
Creation of a supertrack for low acuity patients.

**Category:**
- B: Bed Placement
- C: Clinician Initial Evaluation & Throughput
- E: Exit from the ED

**Key Words:**
- ESI
- Fast Track
- Throughput

**Hospital Metrics:**
- Annual ED Volume: 70,000
- Hospital Beds: 500
- Ownership: Private, Not-For-Profit
- Trauma Level: 1
- Teaching Status: Yes

**Tools Provided:**
- ED SuperTrack Playbook, ACEP
- Super Fast Track Procedures Document
- SuperTrack Patient Info Document

**Clinical Areas Affected:**
- Emergency Department

**Staff Involved:**
- Administrators
- Ancillary Departments
- Clinic Registration
- ED Staff
- Nurses
- Physicians
- Registration Staff
Innovation

Throughput times for low acuity patients were much higher than we were comfortable with (median throughput time for fast track, ESI 4/5s was greater than 110 minutes). Despite multiple efforts to improve efficiency, there had been no improvement in throughput times, in addition, patent volumes have continues to increased approximately 3-7% every year. A number of patient and staff complaints had been occurring, usually due to long wait times and poor flow within the emergency department. Nurses and providers remained frustrated with inefficiencies. Thus we wanted to improving the patient experience by improving flow and removing nurses and provider inefficiencies while continuing to deliver excellent patient care.

We replaced our fast track with a supertrack utilizing a Lean process to improve throughput for our low acuity patients (ESI 4/5). In this model we looked at every step a patient has to undergo as well as the role of each team member prior to discharge from the ED. Each process was looked at to see where waste was occurring and how it could be eliminated. The process was designed to yield the same result regardless of the provider.

Multiple attempts have been tried to improve the workflow and process of this distinct patient population. However, every attempt had failed. Multiple issues had been identified in why the process did not work including:

- Pulling of a team member from the fast track process;
- Failure to implement change management in the culture; and
- Falling back to the 'old ways' when implementing a new process.

Unfortunately a vicious cycle was born with continued failures to improve the process and reinforcement by front line providers that management was not capable (or seemingly supportive of front line) of leading change.

Innovation Implementation

The multidisciplinary team consisted of 10 main players: ED physicians (2 attending physicians and a resident), nursing (1 RN and 1 LPN), nursing director, administration (VP of operations), registration (team leader of registration), ED tech, and process improvement lead. Each person had a distinct role in the creation of the new super track process based on their role. The supertrack treatment team consists of 1 nurse, 1 tech and 1 ED provider (either resident or PA). Other departments were brought in as needed, including laboratory and radiology.

There were several key aspects to the implementation:

1. Creation of an internal waiting room where patients are 'pushed' into after quick triage (patients walk to this area from triage);
2. Keeping patients vertical (patients are kept dressed and moved in and out of treatment rooms to the internal waiting room);
3. Reducing the nursing documentation needed for low acuity patients (previous "requirement" was to do a full nursing assessment on each patient);
4. Team evaluation and discharge (having both the nurse and provider do the evaluation and/or discharge at the same time to reduce duplication);
5. Creation of 'short' notes for providers in the EMR (creation of multiple template macro notes that takes a fraction of the time to complete compared to the traditional note within EPIC);
6. Reorganize key equipment and medications to within the reach of nursing and providers (so they don't have to walk);
7. Preventing the 'pulling' of staff from the supertrack area to other parts of the ED; and
8. Removal of higher acuity patients from the supertrack into the main side if found to be higher acuity than initially thought. (see Super Track Playbook)

Results
In a before and after analysis (12 months prior compared with 12 months after), we went from a median time of 104 minutes to 65 minutes for all ESI 4/5. Patients seen during that time frame had a median of 59 minutes versus 92 minutes during non supertrack hours. Left without being seen dropped by half for ESI 4/5 after the intervention, and almost 90% decrease during supertrack hours compared with non supertrack hours (see SAEM Presentation 2013). While we did see a 9% decrease in ESI 4/5 volume in the after intervention period, we also decreased resources in the implementation (decrease from 5 rooms to 4 rooms) without any other additional resources. We feel strongly that we could easily re-absorb that volume.

**Timeline**
Our planning team took approximately 4 months to setup, with regular meetings approximately every 2-3 weeks. An action plan was created with deadlines and assignment to each member of the team. This 35-item action plan required dedication from each team member to complete.

**Cost/Benefit Analysis**
The only cost was the time spent in the planning process and implementation. No additional cost or resources were needed. In designing this, we did not add any additional equipment or spent any additional funds. In fact, we decreased the number of rooms that we had previously dedicated to this process, from 5 rooms to 4 rooms (3 treatment rooms and 1 internal waiting room). We were able to give back 1 room for use to be seen for higher acuity patients.

**Advice and Lessons Learned**
1. **Planning Process:** Process should be a formal setup and needs to include a wide variety of stakeholders. It is important for stakeholders to share with each other; issues brought by one group can be helpful to others.
2. **Implementation/Boots on the Ground:** We feel that one of the key reasons we were successful is that we had a team member to be on site ("Boots on the Ground") during 'go live. This help answer questions that providers had during with the process. It prevented the providers from reverting back to old habits and processes. It also allowed for instant feedback (good and bad) to help revise any potential issues that were not seen in the planning stage.
3. **A-team members during implementation:** For 'go live', we purposely scheduled those providers (nurses, techs, physicians/MLPs) that we knew would be willing to try the new process. Once we had success (see feedback below), others were willing to adopt and implement it.
4. **Feedback:** We created a feedback loop to all providers on the process including daily posting of metrics. We celebrated (frequently) successes including individual providers who were excelling the process (i.e., we created the "hour" club, those whose monthly median throughput times were less than or equal 60 minutes, and posted those names in the ED every month (see Super Track Playbook) Since most ED providers are competitive in nature, we found that everyone wanted to be on the board, which helped drive the process even more.
5. **Patient education:** We created a handout for patients to describe the process. This was important in helping educate patients and their families/friends to know what to expect. (see Super Track Patient Info Document)

**Sustainability**
We also have a robust quality assurance system looking at 72 hour returns, missed radiographs and complaint management. We had not seen an increase in the number of quality issues with the new process. We have now implemented a similar process modeled after this in 4 other of our other EDs within our health system (ED volume ranges from 40k-80k annual volume). All of these EDs had similar length of stay problems for ESI 4/5. For 2013 year to date for these EDs, 1 of our EDs are performing less than 70 minutes and 3 EDs are now 75 minutes or less.
Tools to Download
- ED Super Track Playbook, ACEP
- Super Fast Track Procedures Document
- SuperTrack Patient Info Document

Related Resources
- Building a Super Track: Use of Lean to Decrease Turnaround Times for Low Acuity Patients, SAEM Presentation 2013
ED SuperTrack Playbook

Prepared by:
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Norfolk, VA 23507
June 23, 2012

Contact: brucelo1@yahoo.com
Executive Summary

Objective
Plan and operationalize a dedicated low acuity (ESI 4&5) treatment area (SuperTrack) within the ED.

Goals
Main Throughput goal: a median Door to Door time of 75 minutes or less (top 10%). Additional goals: a median Door to Provider time of < 20 min; LWBS rates < 2% for ESI 4&5 patients. The SuperTrack should have a favorable impact on customer satisfaction and maximize staffing efficiency while minimizing bed footprint.

Key Elements of ED SuperTrack Implementation

ED Improvement Team Plans and Executes SuperTrack Rollout
The team should include an Executive Sponsor, Physician Lead, Nurse Manager, Midlevel provider (if appropriate), Minor Care Nurse, ED Tech, Registration Rep, and Process Improvement Rep. The team should complete key process improvement planning steps to insure project success.

ESI 4 & 5 Data Analysis Occurs during Planning Phase
Key information: Inflow Curves, LWBS rates, LOS graphs, Door to provider times, % of total volume, chief complaints and ED diagnoses. This information determines hours of operation, staffing needs, and other rollout variables.

“Push from Triage” Takes Traditional Waiting Room Time to Zero
ESI 4 & 5 patients go from triage directly to an internal waiting area (SuperTrack “core”) adjacent to the SuperTrack care space and managed by the SuperTrack team. Registration is done in the SuperTrack, as care delivery allows.

Patients Stay Vertical and Dressed and Do Not “Own” Room
Maximize treatment room utilization by moving patients from the Core into treatment rooms only as needed, for exams or private conversation. Patients move back into the Core during downtimes.

Emphasis On SuperTrack Teamwork and Lean Processes
Team communication is critical for efficient movement of patients into and out of the core. The SuperTrack geography must facilitate the process and equipment needs to be at hand. Nursing and provider documentation, medication policies and the discharge process are tailored to low acuity patients.
ED Process Improvement Team

The Team Guides the Project to Success

- Insure that there is representation on the team from all stakeholders in the SuperTrack process. At a minimum, the team should include an Executive Sponsor, Physician Lead, Nurse Manager, Minor Care Nurse, ED Tech, Registration Rep, and Process Improvement Rep.

- Create an AIM Statement that clearly outlines project goals

<table>
<thead>
<tr>
<th>SNGH SuperTrack AIM Statement (October 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with ESI Level 4 and 5 presenting to SNGH ED for treatment will experience reduced door to door times, from the current baseline of 125 average minutes to the goal of 75 median minutes or less, through the implementation of enhanced patient flow processes, by February 2012.</td>
</tr>
</tbody>
</table>

- Create a Charter (attachment 1)

- Review and discuss the Data (next page).

- Complete process improvement steps and use the tools in the table to insure that the team engages, contributes ideas and understands why the traditional fast-track model falls down.

Process Improvement Tools

<table>
<thead>
<tr>
<th>Current Flow Map</th>
<th>Future Flow Map</th>
<th>Fishbone diagram</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shows current inefficiencies</td>
<td>Shows how things will be with new process</td>
<td>Shows Barriers for reaching the future flow map</td>
</tr>
<tr>
<td>See SNGH model, attachment 2</td>
<td>See SNGH model, attachment 3</td>
<td>See SNGH model, attachment 4</td>
</tr>
</tbody>
</table>

- Setting Priorities for elements in the plan is useful and is represented on the sample fishbone in attachment 4. Not every enhancement needs to be complete by go live.

- Translate your prioritization of tasks into an action plan to manage their implementation. Set dates and assign tasks. Get regular updates from team members.
ESI 4 & 5 Data Analysis

The SuperTrack Data Book

- Key data elements to review include: Inflow Curves, LWBS rates, LOS graphs, Door to provider times, % of total volume, chief complaints and ED diagnoses and payor mix.

- Clearly establish baseline performance in overall throughput, door to provider times and LWBS rates

- Use inflow curves to optimize hours of operation, which may vary by day of week.

- Use inflow curves to determine staffing needs: A team of one provider, one nurse and one tech can handle about 3 patients per hour.

- Analyze the chief complaints and discharge diagnoses of potential SuperTrack patients and tailor provider and nursing documentation and discharge processes to them. The use of “short notes” will greatly speed up care team documentation.

Arrival rates of low acuity patients to NGH by hour of day for Mondays
Patient Flow

The “PUSH” from Triage Eliminates Delays; Patients Stay Vertical

- Patients triaged ESI 4 or 5 should go directly from triage to an internal lounge or “SuperTrack Core.” Visitors should remain in the waiting room.

- From this Core area the patient is placed into a room only for discrete tasks (exams, procedures, discharge). Any patient waiting time is spent in back the core, freeing up the room for other patients. The patient stays vertical, dressed and mobile.

- Set up the Core area on the tracking board as a “bunk-able space,” allowing multiple patients to be placed there. The SuperTrack care team will find it helpful to have the trackboard show the actual location of the patient, even tho it may change often during the patient’s stay.

- Geography and physical plant are a key elements for SuperTrack success. Ideally, patients will be able to self navigate from triage to the SuperTrack Core. Treatment rooms should be steps away from the Core.

![Schematic of patient flow from Triage to SuperTrack Core and from Core to rooms](image)

- Define a process for moving patients out of the SuperTrack if they end up needing more extensive care than SuperTrack can provide.

- Make sure the radiology team understands SuperTrack flow and function and can find patients. Make sure they know where the patient should go after x-ray.
Teamwork

SuperTrack Care Team Must Communicate Constantly

- Patients are mobile in a well executed SuperTrack, and that means the care team must constantly update each other patient placement and care plan.

- Eliminate serial task processing as much as possible. When able, the nurse and provider should take the history together and discharge the patient together. Clearly this is not always possible, but is advantageous when flow allows.

- All care team members should be mindful of times and customer service issues

- Dedicated staff are key to keeping the SuperTrack productive. Techs should not be pulled from the process for other work. A dedicated Provider should be present for the hours the SuperTrack operates.

- In most SuperTracks, the provider will staff patients with an attending. Have the attending carry a phone with a fixed number to facilitate this process in real time, instead of creating a batching bottleneck.

- Non-SuperTrack staff (physicians and nurses) need to watch the flow thru SuperTrack and help out when surge becomes an issue.

- Attending physicians should not wait to be “pulled” to SuperTrack by the provider there: proactive, frequent contact facilitates flow.
Lean Processes

Eliminate Wasted Minutes

• Supplies for common SuperTrack procedures, as well as POC testing machines and supplies, should be immediately available in the geography of the SuperTrack. Steps cause delay.

• The documentation required by low acuity patients need not be as extensive as that done for sicker patients. This is true for the provider’s note and the nursing documentation for the visit.

• Eliminate serial processing as much as possible: it provides no value to the patient. When able, the nurse and provider should work together on the the intake and discharge process. Clearly this is not always possible, but is advantageous when flow allows it.

• Putting easy 3’s thru this process as capacity and flow allow is a smart use of resources.
Go Live

Supports Operations Until “the new way of doing things” just becomes “the way we do things.”

• Widely acknowledge that the 1st several days of the new process will be “ugly” and will be a time to work out kinks and problem solve on the fly.

• Members of the Planning and Implementation team should be “boots on the ground” during the go live, providing coaching and support to the care team.

• Change is stressful and staff may try to revert to old processes if not helped thru the transition period. Patient flow can be confusing initially: extra bodies on the floor will help smooth the flow until staff adjust.

• Celebrate early successes. When throughput times show improvement, make sure everyone knows.

• Consider setting up a recurrent system for acknowledging high performance, such as a “one hour club.”

The “One Hour Club” recognizes SuperTrack Team members who had median times < 60 min.
ED Minor Emergency Care Project Charter

**Project/Problem/Process:**
Variation in the triage and treatment approaches of “lower acuity” Emergency Department (ED) patients results in prolonged throughput times, which correlates with lower patient satisfaction scores. More efficient and organized work processes will expedite care of “lower acuity” patients, specifically those with an Emergency Severity Index (ESI) triage score of 4 and 5.

**Business Case:**

*Baseline measures (efficiency and effectiveness):*
- Total avg daily visits
- Avg daily ESI 4-5 visits
- % of ED patients seen in MEC
- LWBS rates ESI 4-5
- Door to Provider times ESI 4-5
- Door to door times ESI 4-5
- Number of beds dedicated to ESI 4-5 patients
- Targeted Fast-track Satisfaction scores (before and after)

*Expected Benefits:*
- Reduce LWBS ESI 4-5 rates by __________
- Reduce door to provider times ESI 4-5 by __________
- Reduce door-to-door times ESI 4-5 by __________
- Reduce number of beds dedicated to low acuity patients by __________
- Increase Targeted Fast-track Satisfaction scores by __________, or from __________ to __________

**Problem/Opportunity Statement:**
Sentara Southside EDs, to varying degrees, are experiencing surging demands, high acuity levels, and a lack of inpatient bed availability that often results in significant overcrowding and delayed patient throughput. Additionally, the implementation of some recognized best practices for managing patient flow in the ED has been delayed or partial, or failed outright. Customer satisfaction continues to increase in importance in emergency medicine and is tied directly to patient throughput in the our setting. As a result, tight management of patient throughput has become essential.

There is significant opportunity to reformat the care of low acuity ED patients – those with ESI designations of 4 and 5 – which will allow better throughput processes and more effective and efficient use of ED staffing and physical plant resources. These changes will be identified and implemented at SNGH with the goal of improvement in low acuity ED patient wait times and throughput. The ultimate effect will be timely, high-quality patient care that is reflected by improved patient satisfaction scores.
**Mission/Goals Statement:**

Develop future state processes and implementation plan to expedite care of the ED patients with an ESI designation of 4 or 5 that will result in:

1) Reduced wait to see a provider (door to provider times)
2) Reduced total length of stay (door to door times)
3) Increased ED capacity for emergent and urgent patients
4) Decrease in LWBS rates
5) Improved Patient Satisfaction scores from ED Outpatients.

**Project Scope:**

All patients presenting to the SNGH ED with an ESI rating or 4 or 5 (approximately 25% of total volume).

**Project Plan:**

- Project Conceptualization and Best Practice Research – September 2011
- Current State Assessment - October 2011
- Future State Design - November 2011
- Action Plan Development - December 2011
- Staff selection, Education and Training – January 2012
- Pilot Implementation - February 2012

**Resources:**

- Team Leader: Moss Mendelson, MD
- Team Members: Michelle Berrios, Debra Kerr, Lynn Holder
- Subject Matter Experts: Other ED Physicians and Nurses as needed
- Operational Executive/Sponsor/Process Owner:

**Key Customers:** SNGH ED Patients, ED Physicians, ED Nursing staff
### Super Fast Track (SFT)

**Hours of operation**
- Mon-Th: 0900-2300
- Fri-Sun: 1100-2300

**Purpose:**

To provide SNGH ED employees with instructions on managing SFT during assigned shifts.

**Job Aid:**

1. SFT will be staffed by 1 provider, 1 nurse and 1 tech. The SFT staff is not to be “pulled” to cover other areas during hours of operation.
2. Patient gets quick registered and triaged. If the patient is Medicare/Tricare insured, a blue dot will be placed on the labels during quick registration.
3. If the patient is deemed an ESI 4 or 5, the patient is handed their labels in an enclosed folder along with the SFT info sheet.
4. No visitors will accompany the patient to SFT, with the exception of minors or patients or those that may be mentally challenged.
5. The patient is “pushed” (walks themselves) back to the SFT Core (Rm 6).
6. The patient will hand carry their labels in the enclosed folder and place in bin at nurses station.
7. Registration will be completed while the patient is in the Core/SFT area. Registration is to be completed around the provider’s assessment/exam.
8. Patients will be moved from the SFT Core to beds 7-9 as needed for exams, procedures, and consultation/discharge by the assigned nurse, tech or provider. (The pt is also moved in the Epic tracking system). When possible the nurse and provider will evaluate the patients at the same time.
9. After assessing the patient, a focused assessment is to be documented in the nursing notes section of the EMR. (it is not necessary to complete the entire WDL flow sheet on SFT patients)

10. Once the exam/procedure is completed and/or IV/IM medications have been given, the patient will either be discharged directly from the exam room or will return back to the Core to wait for the necessary observation period post IM/IV medication or for results.

11. If SFT becomes over populated and the provider/nurse is getting behind. Notify an attending MD and the charge nurse for assistance.

Process to Remove Under Triaged Patients:

1. If available (and sicker patients are not waiting), move the under triaged SFT patient to an open room in the ED.
2. If no room is immediately available and the Core is not full, keep the patient in the Core until an open room becomes available.
3. If the Core is full, move the patient back to the waiting area.
4. Consider drawing labs/ordering pre-emptive studies prior to #2 or #3.
5. Have a Clin II change the ESI score on under triaged patients. (triage times are not to be changed strictly because thru put times are not being met. Only for the under triaged)

Charges:

1. Complete charges per ED standard, use the “Discharged from MEC” option under ED Disposition.
2. If the patient was not fully registered during their SFT visit. Direct them to the registration window upon discharge.
Sentara Norfolk General Emergency Department SuperTrack

Your time is important to us!

To provide a more efficient patient experience in our emergency department, we have redesigned the way you will receive your care today. Based on the initial assessment of the triage nurse you saw when you came in, you are going directly to our new ED SuperTrack.

In the SuperTrack, you will receive your care from the same Norfolk General ED professional staff that you already trust, but in a way that moves you more quickly through the system without compromising the quality that you expect.

Some Changes you may notice in the SuperTrack:

• SuperTrack is designed around national emergency department best practices.
• Our goal is to get you in and out in under 90 minutes!
• You may not stay your entire visit in a single room.
• The staff providing your care is dedicated to the SuperTrack.
• The staff will focus on your acute complaint.
• Unless you have special mobility needs, we will ask your family and friends to remain the waiting room while we see you, to keep the process efficient for all of our SuperTrack patients.
• If your condition is more complicated than we initially thought, we will switch you into our main treatment area and provide the extended services you need.

Some things haven’t changed:

• We will continue to provide high quality care that is tailored to you.
• We will keep you and our staff safe.
• We care about you and appreciate the opportunity to meet your healthcare needs.

We want your feedback!

You may receive a short survey about how your visit went today. Please fill it out and turn it into the staff at the end of your visit.
Building a Super Track: Use of Lean to Decrease Turnaround Times for Low Acuity Patients

Bruce M. Lo¹, Moss H. Mendelson¹, Lynn Holder², Michelle Berrios², Debra Kerr²

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²Department of Emergency Medicine, Sentara Norfolk General Hospital, Norfolk, VA
Disclosures

No Financial Conflicts of Interest to Disclose
Introduction

- ED Volumes: Increasing
- ED Throughput: Competitive
  - Financial
  - Patient Satisfaction
  - CMS reporting
  - Patient Safety
- Lean Methodology
Methods

- Single center, before-after study
- Academic center
  - ~70k/year, 21% Admission rate
  - 39 Bed ED
  - ~13% ED occupancy lost to hospital boarders
- Super Track: 3 person team
  - PA or Resident (PGY-2 or PGY-3)
  - 1 RN or LPN
  - 1 Tech
- ST: 12-14 hours a day
Methods

- 24 months
  - Pre-intervention: Jan 4, 2011 – Jan 3, 2012

- Inclusion: All ESI 4/5
- Exclusion: Admitted or Dialysis

Outcomes
- Primary Outcome: Median LOS
- Secondary Outcome: LWBS
Super Track Volume by Year and Time Frame

31,333

2624 excluded: dialysis or admitted

2011

15,040

2012

13,699

ST

9,435

Non-ST

4,236
Results
## Median LOS: 2011 vs. 2012

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Median (IQR)</td>
</tr>
<tr>
<td>15,040</td>
<td><strong>104 (71-149)</strong></td>
</tr>
</tbody>
</table>

### Graph
- **Y-axis:** Minutes
- **X-axis:** Jan, Feb, Mar, Apr, May, Jun, Jul, Aug, Sept, Oct, Nov, Dec
- **Legend:**
  - Blue line: 2011
  - Red line: 2012

### Notes
- **Difference:** 39 minutes, 38% reduction
- **P-value:** < 0.0001 (statistically significant)
**Median LOS: ST vs. Non-ST**

<table>
<thead>
<tr>
<th></th>
<th>Super Track</th>
<th>Non-Super Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>9,435</td>
<td>4,236</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>59 (44-75)</td>
<td>92 (61-140)</td>
</tr>
<tr>
<td>Difference</td>
<td>33 (36%)</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>&lt; 0.0001</td>
<td></td>
</tr>
</tbody>
</table>

- ST: 59 minutes (IQR: 44-75 minutes)
- Non-ST: 92 minutes (IQR: 61-140 minutes)

Difference: 33 minutes (36%), P < 0.0001
## Left Without Being Seen

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>P value</th>
<th></th>
<th>N</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>243</td>
<td>&lt; 0.0001</td>
<td>Non-ST</td>
<td>20</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>2012</td>
<td>103</td>
<td></td>
<td>ST</td>
<td>83</td>
<td></td>
</tr>
</tbody>
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### Bar Chart

- **2011**
  - Non-ST: 243
  - ST: 103
- **2012**
  - Non-ST: 20
  - ST: 83

- Percentage
  - 2011 Non-ST: 0.75%
  - 2011 ST: 1.59%
  - 2012 Non-ST: 1.92%
  - 2012 ST: 0.21%
Discussion

- Lean process can decrease LOS/LWBS
  - Decrease 38% / 50%
- No additional resources
  - Decrease from 5 rooms to 4 rooms
- Consistent Performance
- Culture Change
Limitations

- Decrease in volume of ESI 4/5
- Didn’t measure Patient satisfaction or Provider satisfaction
- Didn’t measure Patient outcomes
Questions?