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High Impact ED Patient Flow Interventions Table

Process Issues	Tier 1 Interventions	Tier 2 Interventions	Tier 3 Interventions
Overprocessing: more steps than necessary	Eliminate RN triage Use quick registration	Use ambulance bedside registration	Use exit registration for discharged patients
Sequentialism: one thing must happen before other	Establish a Rapid Clinical Evaluation System	Establish an early patient processing system	Immediate disposition for low-acuity patients
Idling: nothing being done between processing steps	Use internal wait areas Avoid ED waiting room	Use processing areas for unbedded patients	Establish phlebotomy and imaging at intake
Waste: excess distance and motion; redundancy	Eliminate repetitive documentation	Establish everything in reach "hub of control"	Pre-stocked trays/carts for common procedures
Assets Issues	**Tier 1 Interventions**	**Tier 2 Interventions**	**Tier 3 Interventions**
Underutilization: unused capacity or staff resources	Turn fast-track into an intermediate acuity area	Use transit area/chairs for low-acuity patients	Use treatment chairs for respiratory/IV Therapy
Segregation: some areas overwhelmed-others quiet	Eliminate specialized areas (all beds for all)	Place monitors in all ED beds and areas	Use Pediatric area only if > 30% of all ED volume
Staff Entrapment: staff is unable to float/specialized	Require staff rotation in all ED areas	Cross-train all clinical staff to see/care for all patients	Cross-train techs for all duties (ortho, ECG, etc.)
People Issues	**Tier 1 Interventions**	**Tier 2 Interventions**	**Tier 3 Interventions**
Productivity outliers: staff to left of Bell-curve	Eliminate staff productivity outliers ("D-Players")	Develop staff productivity rankings and post	Establish productivity-based compensation
Response outliers: poor response times	Establish log for ancillary response times and post	Establish a “30-min consultant response”	Ban consultant response outliers from ED call
Controls Issues	**Tier 1 Interventions**	**Tier 2 Interventions**	**Tier 3 Interventions**
Operations: no Operating Procedures/capacity plans	Establish standard operating procedures	Establish ED queue management protocols	Establish Acute ED decompression plans
Schedule: Detrimental staff combinations/levels	Establish productivity-based schedule	Adjust staffing to peak volume days/shifts	Eliminate staff-led self-scheduling policies
Interfaces Issues	**Tier 1 Interventions**	**Tier 2 Interventions**	**Tier 3 Interventions**
Inbound: delivers services or results (lab, X-ray, etc.)	Establish shared goals and metrics with ED	Use ED phlebotomy team/ targeted POC	Dedicated x-ray suite for ED patients
Competitive: competes for beds (recovery, OR)	Smooth out/cap OR elective schedule	Eliminate surgical block scheduling	Allocate one OR Suite for unscheduled cases
Outbound: Receives ED patients (ICU and floors)	Establish “30-minute to clean ready-bed” goal	Establish an EDTU and an inpatient D/C Lounge	Establish “Full-capacity protocol” (to IP hallways)
Enablers	**Tier 1 Interventions**	**Tier 2 Interventions**	**Tier 3 Interventions**
Silo operations: shields bad processes/staff	Establish Institutional shared patient flow metrics	Establish Bed capacity optimization teams	Hire an ED patient flow coordinator
Competing priorities: prevents "pull” of ED admit	Establish Sentinel-event approach to IP "blocking"	Establish a “3-beds-ahead” program	Tie compensation to Patient Flow goals

EDTU=ED transitional unit; POC=Point-of-Care testing; IP=inpatient; OR=Operating Room