Hardwiring Hospital-Wide Flow To Drive Competitive Performance

Thursday, July 9, 2015   |   2:00PM - 3:00PM EST
Your Presenters

Thom Mayer, MD, FACEP, FAAP
CEO, BestPractices
Executive VP, EmCare

Kirk Jensen, MD, MBA, FACEP
CMO, BestPractices
Chief Innovation Officer, EmCare
In the Perpetual Whitewater Of Change, what are the C-suite’s #1 goals?

- Becoming the high quality, cost-efficient provider of care
- Delivering the Results that Matter
- Becoming an Expert Change Accelerator
Shared Mental Models
Aligned Strategic Incentives
Rule #1, Rule #2…
Flow and Execution

“Some is not a number. Soon is not a time. Somehow is not a strategy.”

*The Patient Flow Advantage*

Jensen/Mayer - 2015
HARDWIRING FLOW
Adding Value, Eliminating Waste

© T. Mayer, K. Jensen
Hardwiring Flow
Systems and Processes for Seamless Patient Care

Thom Mayer, MD, FACEP, FAAP
Kirk Jensen, MD, MBA, FACEP

- Why patient flow helps organizations maximize the “Three Es”: Efficiency, Effectiveness, and Execution
- How to implement a proven methodology for improving patient flow
- Why it’s important to engage physicians in the flow process (and how to do so)
- How to apply the principles of better patient flow to emergency departments, inpatient experiences, and surgical processes
Flow Resources
Hardwiring the Definition of Flow

*Flow* is defined as **adding value** and **decreasing waste** to processes, services or behaviors by increasing benefits, decreasing burdens, (or both) when applied to the movement of our patients through our service transitions and queues.
Becoming a “Flow Detective”

- A continuous **Treasure Hunt** to add value
- A continuous **Bounty Hunt** to eliminate anything which doesn’t add value (waste)
The Dynamic Tension Of Leadership

WHY?
Why are we doing it THIS way?
EXECUTION
Value-Added

WHY NOT?
Why not do it THAT way?
AGILITY
Waste-Reduction
The Value-Added Equation

What are the BENEFITS RECEIVED?

OBVIOUS?
Re-affirm them

NON-OBVIOUS?
Inform them

What are the BURDENS ENDURED?

NECESSARY?
Explain them

UNNECESSARY?
Eliminate them
(Waste)
Waste-Example

At 2 PM, a patient is discharged from a med-surg floor at your hospital...

- **Who** puts the bed back in service?
- **What steps** need to be taken to do that?
- **What are the** rate-limiting steps or **bottlenecks**?
- What is the **incentive** to do so?
Do Your...

HOSPITALISTS care about...
ED boarders, LOS, patient satisfaction?

EMERGENCY PHYSICIANS care about ...
Hospital bed turns, LOS, core measure compliance, finances, readmissions?

RADIOLOGISTS care about ...
Oral contrast in abdominal CTs, plain film TAT?

If Not, Why Not?
Teams and Teamwork:
It’s About Your Processes…and Your Handoffs…
Teams and Teamwork:
Handoffs, Turnovers, and Teamwork
The #1 Reason to Hardwire Flow?
A healthcare system that works...
For our patients...For our team...For us!
MONETIZING FLOW
The Benefits Of Flow To Your Bottom Line

© T. Mayer, K. Jensen
## The Cost – It Adds Up

<table>
<thead>
<tr>
<th>1.9 million</th>
<th>$1,086</th>
<th>$9,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>In 2007, 1.9 million people – representing 2% of all ED visits – left the ED before being seen. These walk-outs represent significant lost revenue for hospitals.</td>
<td>A 2006 study found that each hour of ambulance diversion was associated with $1,086 in foregone hospital revenues.</td>
<td>A recent study showed that a 1-hour reduction in ED boarding time would result in over $9,000 of additional revenue by reducing ambulance diversion and patients who left without being seen.</td>
</tr>
</tbody>
</table>

# A Case Study

There is a Compelling Business Case for Flow-

<table>
<thead>
<tr>
<th>ER Patients</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>40,000 ED Visits x 1 Hr Reduction in LOS</td>
<td>40,000 Hours of ↑ED Capacity/ Year</td>
</tr>
<tr>
<td>40,000 Hours of ↑ED Capacity/ 2 Hours per ED Visit</td>
<td>20,000 potential new visits/year</td>
</tr>
<tr>
<td>20,000 new ED visits x $100/visit in physician revenue</td>
<td>$2,000,000 new revenue for the group</td>
</tr>
<tr>
<td>20,000 new ED visits @ $400/visit for the hospital</td>
<td>$8,000,000 new revenue per year for the hospital</td>
</tr>
</tbody>
</table>

### ER Admissions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>New hospital admissions at $3,000 - $7500 per admission</td>
<td>1 more admission per day (365) X $3,000-$7500/ patient admission =$1,095,00-$2,737,500/year</td>
</tr>
<tr>
<td>50% or more of hospital admissions come through the ER</td>
<td><em>(AHRQ-only 6.2% of admissions through the ED are uninsured)</em></td>
</tr>
</tbody>
</table>
# RAP&GO - Expediting Admissions
## Increased Hospital Revenue

<table>
<thead>
<tr>
<th>Admitted Patients</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freed Up ER Bed Time</td>
<td>30 Hours</td>
</tr>
<tr>
<td>Average ER Patient LOS</td>
<td>3 Hours</td>
</tr>
<tr>
<td>Additional New ER Patients Seen</td>
<td>10 Per Day</td>
</tr>
<tr>
<td>ER Admission Rate</td>
<td>20%</td>
</tr>
<tr>
<td>New Admissions Per Day</td>
<td>2</td>
</tr>
<tr>
<td>New Admissions Per Year</td>
<td>730</td>
</tr>
<tr>
<td>Average Hospital Revenue Per Admit</td>
<td>$7,500</td>
</tr>
<tr>
<td><strong>New Hospital Revenue</strong></td>
<td><strong>$5,475,000</strong></td>
</tr>
</tbody>
</table>
The 7 Strategies of Hardwiring Flow

1. Demand-Capacity Management
2. Forecasting Demand
3. Real-Time Monitoring of Flow
4. Queuing Theory
5. Managing Variation
6. Eliminating Bottlenecks
7. Flow as a Complex Adaptive System
The Key Questions

- Who’s coming?
- When are they coming?
- What are they going to need?
- Is our service capacity going to match patient demand?

And what will we do if or when capacity doesn't match patient demand?
Measure and Act on Demand Capacity Issues

Emergency Department clinician staffing mapped against patient arrivals and acuity by hour of the day (HOD) … and day of the week (DOW)…
Hardwiring Patient Flow:
Critical Patient Flow Tactical Concepts: Part 1

- The front door and your front end processes drive flow
- Triage is a process, not a place
- Get the patient and the doctor together as quickly and efficiently as possible
- “Fast track” is a verb, not a noun
- For horizontal patients, real estate matters; for vertical patients, speed matters
- The more horizontal you are the more you are a patient... the more vertical you are the more you are a customer...

Thom Mayer/Kirk Jensen - Hardwiring Flow
Keep your vertical patients vertical and in motion

Be fast at fast things and slow at slow things

The number one sign of the health of an ED, OR, PACU, ICU, or hospital floor is the relationship between the physicians and the nurses

Making people unhappy and sending them a bill is not a healthy business model

If your boarding burden is overwhelming, you are....!@!&%#!
Kill Ya’s

- Inadequate nurses
- Inadequate essential services
- Long TAT, lab, imaging
- EMR
- Medical staff disengaged
- Hospitalists vs. Dischargists
- Unmotivated staff
- Lack of accountability
- No BABA
- No Adopt A Boarder
- Disconnect between the ED and the rest of the hospital

Love ‘Ems

- Appropriate staffing
- Flex staffing
- Team-based
- Registration a part of the team
- Highly metrics-based
- Clear idea of success
- Clear TAT goals
- Service relationship w/essential services
- Effective use of MLPs and Residents
- Spectra-link phones
- Scribes
- Hospital-Wide Flow
Hardwiring Flow-Triage Adds Value

DOES TRIAGE...
1. Improve throughput?
2. Increase safety?
3. Improve satisfaction?
4. Improve quality?
5. Provide information?
6. Increase revenue?

If not…Why not…Change It…NOW!
Keep Vertical Patients Vertical-and Moving!

**Patient**
- Dependent
- Passive
- Less Choice
- Control with Us
- Clarity

**Customer**
- Economic
- Independent
- Choice
- Discretionary Purchase
- Control with Them
- Diffuse - Unclear

Thom Mayer, MD & Kirk Jensen, MD
The Flow Cascade
A Set of Solutions to Flow

Triage Bypass
Advanced Triage/Initiatives
Team Triage & Treatment (T3)
Provider in Triage (PIT)
Patient

Bedside registration
Fast Track
Level 3 Fast Track
Supertrack/Ultratrack
Results Waiting Room

Early Decision to Admit
Door to Discharge Program
Express Admission Units
ICU Fast Tracking
Dedicated Discharge Process
ACCELERATING FLOW INTO YOUR HOSPITAL
Hospital-Wide Flow and the Myth of 100% Utilization

Small changes in utilization can lead to big changes in service and throughput.

Average Time in Clinic

Utilization as Percent

Courtesy Chuck Noon, PhD, PEMBA
© T. Mayer, K. Jensen
PARTNERING WITH HOSPITAL MEDICINE
Hospital-Wide Flow Options

- Early Decision to Admit-“In or Out?”
- Early Request for a Bed-Be a Bed Ahead
- EBM Bed Selection (EKG and POC Troponin)
- Rapid Admission Process
- Express Admitting Units
- ICU Fast Tracking
- Adopt-a-Boarder
- Real-Time Demand-Capacity Management
STONECREST MEDICAL CENTER
47K Annual ED Visits
Before and After EBM Guidelines

Decreased “ER boarding time” by over 2.50 hours

BEFORE Rapid Admission Process
ED >3.5 Hours (210 minutes)
Floor

AFTER Rapid Admission Process
ED <45 Minutes
Floor
Many units/departments attempt to optimize patient flow

- Sub-optimizing flow in other areas
- Sub-optimizing flow throughout the entire acute care system
This Is Not Your Typical Hospital-Wide Bed Meeting

Hospitals require an administrative system for flow that at the unit level:

✓ Predicts capacity
✓ Predicts demand
✓ Documents a plan if demand is predicted to be greater than capacity
✓ Evaluates the success or failure of predictions and plans
✓ Uses failures and successes of predictions and plans to develop the key improvement projects to improve flow
Putting the Psychology of Waiting to Work

Unoccupied time feels longer than occupied time
- TVs, magazines, health care material
- Company-friends and family
- ROS forms, kiosk, pre-work
- Frequent “touches”

Pre-process waits feel longer than in-process waits
- Immediate bedding
- No triage
- AT/AI (Advanced Treatment/Advanced Initiatives)
- Team Triage

Anxiety makes waits seem longer
- Making the Customer Service Dx and Rx
- Address the obvious-pre-thought out and sincerely deployed scripts
- Patient and Leadership Rounding

Uncertain waits are longer than known, finite waits
- Previews of what to expect
- Expectation Creation
- Green-Yellow-Red grading and information system
- Traumas, CPRs-Informed delays
- Patient and Leadership Rounding

Unexplained waits are longer than explained waits
- In-process preview and review
- Family and friends
- Patient and Leadership Rounding

Unfair waits are longer than equitable waits
- Announce Codes
- Fast Track Criteria known and transparent

The more valuable the service, the longer the customer will wait
- The Value Equation - Maximize benefits for the patient and significant others + Eliminate burdens for the patient and significant others

Solo waits feel longer than group waits
- Visitor Policy-The Deputy Sheriff takes a furlough
- Managing the family’s expectations
- It’s OK to leave for awhile
- On-stage/Offstage
Finding Flow

Finding flow requires...

- Asking “Why” and “Why Not?” Incessantly
- Getting them with you on the takeoff
- Creating hope...
- Taking people out of their comfort zones
Parallel Processes Improve Flow

Before: Sequential Processing

1. Patient Arrival in ED
2. EM Physician work up
3. EM calls HM Physician
4. HM Assumes Care
5. Patient Admitted

 Parallel Processes Improve Flow
Before: Sequential Processing
Parallel Processes Improve Flow

After: Parallel Processing

- Start
  - Patient Arrival in ED
    - EBM Work-Up (EM=HM)
      - EM-HM Collaborate
        - HM Assumes Care
          - Patient Admitted
Changing Physician Behavior

“Excellence is what we strive for—but consistency is what we demand.”

Spinoza
Engaging Doctors = Engaging People

What is our true goal?

A healthcare system that works…

For our patients…
For our team…
For us!
Holding Professionals Accountable

- This is sometimes difficult
- But it’s really not complicated…
- No one wants to be in the bottom third
- Data drives the train-Docs are scientists
- Make it transparent and simple
- Accentuate A Team Members and Behaviors
- Revisit the numbers frequently (every month)
- Have the courage and the culture to coach and mentor
6 Steps to Holding Docs and Nurses Accountable

1. Clearly state what the group values. (What is the ideal emergency physician?)
2. Make the generation of what the group values a team-oriented process (including patients, nurses, and the medical staff).
3. What the group values must be clear, measurable and succinctly-stated.
4. Make the results transparent and easily-available.
5. The results must be actionable and capable of “fixing.”
6. The group must be open to coaching and mentoring when results are below target levels.
Coaching and Mentoring
Changing the Culture

- Move the entire curve
- Where do you spend your time? Hint: 80/20
- Decrease variation that doesn’t add value
The Patient Flow Advantage:
How Hardwiring Hospital-Wide Flow Drives Competitive Performance
Kirk Jensen/Thom Mayer  FireStarter Publishing,  November/December 2015

Foreword
Introduction

Section 1 — Framing the Flow Mandate
Chapter 1: Why Flow Matters
Chapter 2: Defining Flow: Establishing the Foundations
Chapter 3: Strategies and Tools to Hardwire Hospital-Wide Flow
Chapter 4: Lessons from Other Industries

Section 2 — Advanced Flow Concepts
Chapter 5: Emergency Department Solutions to Flow: Fundamental Principles
Chapter 6: Advanced Emergency Department Solutions to Flow
Chapter 7: Hospital Systems to Improve Flow
Chapter 8: Hospital Medicine and Flow
Chapter 9: Real-Time Demand and Capacity Management

Section 3 — Frontiers of Flow
Chapter 10: Hardwiring Flow in Critical Care
Chapter 11: Smoothing Surgical Flow
Chapter 12: Acute Care Surgery and Flow
Chapter 13: Integrating Anesthesia Services into the Flow Equation
Chapter 14: The Role of Imaging Services in Expediting Flow
Chapter 15: The Future of Flow

References
About the Authors
Acknowledgments
Additional Resources
Additional Reading by Authors
Thom Mayer, MD, FACEP, FAAP  
Kirk Jensen, MD, MBA, FACEP

- Why patient flow helps organizations maximize the “Three Es”: Efficiency, Effectiveness, and Execution
- How to implement a proven methodology for improving patient flow
- Why it’s important to engage physicians in the flow process (and how to do so)
- How to apply the principles of better patient flow to emergency departments, inpatient experiences, and surgical processes
Strauss and Mayer’s Emergency Department Management

- By Robert W. Strauss MD, Thom A. Mayer, MD
- Kirk B Jensen, MD, MBA, FACEP, Associate Editor
- Publisher: McGraw-Hill Professional
- Publication date: January 2014
- Thom Mayer, one of two chief editors, co-authored 20+ chapters
- Rob Strauss, one of two chief editors, co-authored 20+ chapters
- Kirk Jensen, one of two associate editors, co-authored 11 chapters as well as serving as section editor of the Operations: Flow section.
Patient Flow: Reducing Delay in Healthcare Delivery, 2nd Ed.

1. Modeling Patient Flows Through the Healthcare System, RANDOLPH HALL, DAVID BELSON, PAVAN MURALI AND MAGED DESSOUKY
2. Hospital-wide System Patient Flow-ALEXANDER KOLKER
3. Hospitals And Clinical Facilities, Processes And Design For Patient Flow MICHAEL WILLIAMS
4. Emergency Department Crowding-KIRK JENSEN
5. Patient Outcomes Due to Emergency Department Delays- MEGHAN MCHUGH
6. Access to Surgery and Medical Consequences of delays BORIS SOBOLEV, ADRIAN LEVY AND LISA KURAMOTO
7. Breakthrough Demand-Capacity Management Strategies to Improve Hospital Flow, Safety, and Satisfaction-LINDA KOSNIK
8. Managing Patient Appointments in Primary Care-SERGEI SAVIN
9. Waiting Lists for Surgery-EMILIO CERDÁ, LAURA DE PABLOS, MARIA V. RODRÍGUEZ-URÍA
10. Triage and Prioritization for Non-Emergency Services-KATHERINE HARDING
11. Personnel Staffing and Scheduling-MICHAEL WARNER
13. Using Simulation to Improve Healthcare: Case Study-BORIS SOBOLEV
15. Forecasting Demand for Regional Healthcare-PETER CONGDON
16. Queueing Analysis in Healthcare -LINDA GREEN
17. Rapid Distribution of Medical Supplies - MAGED DESSOUKY, FERNANDO ORDÓÑEZ, HONGZHONG JIA, AND ZHIHONG SHEN
18. Using a Diagnostic to Focus Hospital Flow Improvement Strategies ROGER RESAR
19. Improving Patient Satisfaction Through Improved Flow- KIRK JENSEN
20. Continuum of Care Program- MARK LINDSAY
21. A Logistics Approach for Hospital Process Improvement-JAN VISSERS
22. Managing a Patient Flow Improvement Project-DAVID BELSON
Leadership for Smooth Patient Flow: 
Improved Outcomes, Improved Service, Improved Bottom Line

Kirk B. Jensen, MD, FACEP
Thom A. Mayer, MD, FACEP, FAAP
Shari J. Welch, MD, FACEP
Carol Haraden, PhD, FACEP

The heart of the book focuses on the practical information and leadership techniques you can use to foster change and remove the barriers to smooth patient flow.

You will learn how to: Break down departmental silos and build a multidisciplinary patient flow team Use metrics and benchmarking data to evaluate your organization and set goals Create and implement a reward system to initiate and sustain good patient flow behaviors Improve patient flow through the emergency department—the main point of entry into your organization The book also explores what healthcare institutions can learn from other service organizations including Disney, Ritz-Carlton, and Starbucks. It discusses how to adapt their successful demand management and customer service techniques to the healthcare environment.

“This book marks a milestone in the ability to explain and explore flow as a central, improvable property of healthcare systems. The authors are masters of both theory and application, and they speak from real experiences bravely met.”

Donald M. Berwick, MD
President and CEO
Institute for Healthcare Improvement (from the foreword)

ACHE + Institute for Healthcare Improvement
The Hospital Executive’s Guide to Emergency Department Management

Kirk B. Jensen, MD, FACEP
Daniel G. Kirkpatrick, MHA, FACHE

Table of Contents:
Chapter 1: A Design for Operational Excellence
Chapter 2: Leadership
Chapter 3: Affordable Care Act Impact—What Healthcare Reform Means for the ED
Chapter 4: The Impact of Specialized Groups and Populations on the ED
Chapter 5: Fielding Your Best Team
Chapter 6: Improving Patient Flow
Chapter 7: Ensuring Patient Satisfaction
Chapter 8: Implementing the Plan
Chapter 9: Culture and Change Management
Chapter 10: Patient Safety and Risk Reduction
Chapter 11: The Role and Necessity of the Dashboard
Chapter 12: Physician Compensation: Productivity-Based Systems
Chapter 13: Billing, Coding, and Collections
Chapter 14: The Business Case
The Definitive Guide to Emergency Department Operational Improvement
Improving Patient Flow in the Emergency Department

There are nine strategies hospitals can incorporate to more effectively manage patient flow in the emergency department without sacrificing quality of care.

1. Improve patient flow in the ED: hospitals should develop a strategy to reduce the patient flow time, which is defined by the time a patient enters the emergency department and is discharged or admitted to a hospital bed. Strategies may include triage process improvements, identification of high-volume procedures, and establishment of partnerships with local hospitals.

2. Enhance patient care coordination: hospitals can improve patient care coordination by implementing electronic health records, providing real-time access to patient information, and ensuring timely communication among healthcare providers.

3. Enhance patient experience: hospitals can enhance patient experience by providing clear and concise information, addressing patient concerns in a timely manner, and providing a comfortable and welcoming environment.

4. Enhance staff productivity: hospitals can enhance staff productivity by implementing time-saving technologies, such as automated medication dispensing systems, and providing ongoing training and support for healthcare providers.

5. Enhance supply chain management: hospitals can enhance supply chain management by implementing robust inventory management systems, ensuring timely delivery of supplies, and reducing waste and overstocking.

6. Enhance technology utilization: hospitals can enhance technology utilization by implementing Electronic Health Records (EHRs), improving security and access controls, and integrating technology into patient care processes.

7. Enhance appointment scheduling: hospitals can enhance appointment scheduling by implementing appointment scheduling software, providing online appointment scheduling, and offering alternative scheduling options.

8. Enhance patient flow planning: hospitals can enhance patient flow planning by implementing flow planning software, providing real-time data visualization, and implementing patient flow management processes.

9. Enhance patient care coordination: hospitals can enhance patient care coordination by implementing care coordination software, ensuring timely communication among healthcare providers, and providing a clear and concise patient care plan.

By implementing these strategies, hospitals can improve patient flow in the emergency department, resulting in improved patient satisfaction, reduced wait times, and improved overall quality of care.

Reference:

© T. Mayer, K. Jensen
Real-Time Demand Capacity Management and Hospital-Wide Patient Flow

The Joint Commission Journal on Quality and Patient Safety
May 2011 Volume 37 Number 5
Managing Patient Flow in Hospitals: Strategies and Solutions, Second Edition

Chapter 8
Improving Hospitalwide Patient Flow at Northwest Community Hospital

From a systems standpoint, hospitals have inputs (patients coming to the hospital, throughput; patients being treated or admitted), and outputs (patients being released). Flow is defined as the movement of these patients into, through, and out of the hospital. How efficiently this movement is accomplished determines the rate of flow through the hospital, if not throughout the entire health care system.

Many factors control the flow within the hospital. First, barriers to entry may slow or stop the flow. In the emergency department (ED), for example, the inability to get patients admitted contributes to patient flow building that strains staff and creates long waits, sometimes compromising quality of care or intensifying admissions. In the ICU, transfers of patients to the floor can be delayed by the unsuitability of beds, keeping patients waiting for needed ICU space. Patients often must be moved to less than ideal places because the system is not flowing smoothly, compromising the quality of patient care. Second, barriers to exit can slow or stop the flow, as well. If a patient is not discharged in an efficient and timely way, a needed and valuable space is rendered unavailable for longer than is necessary, creating backups throughout the system. Prenaturally, barriers to exit help create the barriers to entry. If patients cannot get out, new patients cannot get in.

As the venerable and ever-interesting Yogi Berra once said, "People don’t get them anymore. It’s too crowded." Although this expression probably only made sense to Yogi, it is in fact the incentive for hospitals to work on improving patient flow and throughput. In the health care industry, patient service and patient safety are paramount. In the current economic and reimbursement climate, collecting every hard-earned dime can be tantamount to survival. The service and safety compromises, as well as the loss of income derived from hospitals going on bypass or diversion, or from patients leaving before being seen, or from prolonged inpatient stays, simply cannot be tolerated.

Furthermore, although it may not be rocket science, optimizing patient flow is surprisingly analogous to get from launch to landing quickly and safely. Throughout as it has been around since ancient times, or waiting lines, were first analyzed by A.K. Erlang in 1913, in the context of telephone facilities.

Industries as diverse as airlines, trucking, and fast-food drive-throughs have since made use of queuing theory, computer simulation, and smoothing demand to maximize throughput and optimize resource allocation. Despite its proven ability to better serve customers, reduce costs, and improve safety, health care has been late to jump into the science of operations management (OMS).
The Improvement Guide and Rapid-Cycle Testing

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP.


Benchmarking Resources

Where to find data

Your neighbors
  • Call and/or visit

ACEP
  • http://www.acep.org

Premier
  • www.premier.com

VHA
  • www.vha.com

ED Benchmarking Alliance
  • www.edbenchmarking.org

UHC
  • www.uhc.org

Be sure to compare hospitals with similar acuity and similar volume…
References

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References

• Shook, J. *Managing to Lean: Using the A3 management process to solve problems, gain agreement, mentor and lead.* Cambridge, MA, Lean Enterprise Institute: 2008.
References

References:
The Psychology of Waiting


