



WFNHP/St. Francis Hospital Project

Final Report
October 2012

With support from the Albert Shanker Institute, the Wisconsin Federation of Nurses and Health Professionals (WFNHP) and the management of St. Francis Hospital in Milwaukee, WI organized a joint project to improve patient care and patient satisfaction. The purpose of the project was to determine whether greater reliance on front-line staff would lead to more significant and more sustainable improvements in patient care and patient satisfaction than the usual top-down approach.

The focus on patient satisfaction offered a particularly good opportunity for collaboration between the union and management, since both have a common interest in making improvements. Patient satisfaction scores are now being reported to the public to promote competition among hospitals based on quality of care, so anyone with access to a computer can go online and compare scores among possible providers. If St. Francis could achieve higher scores than its competitors, it could gain a reputation in the community as the best place to go for care. On the other hand, poor performance could hurt the hospital financially, since it could be penalized by reductions in its Medicare reimbursement rates. St. Francis was particularly vulnerable in this regard because it had a high percentage of Medicare patients – around 60-70 percent.

Poor performance could also put the union at risk. St. Francis is the only unionized facility in the Wheaton Franciscan Healthcare system, and it had recently closed down a poorly performing hospital elsewhere in Milwaukee and built a brand new facility in the same market as St. Francis. In addition, St. Francis is located within a few blocks of the flagship facility of the Aurora Health Care system.

The approach of relying on front-line staff to make improvements was attractive to both management and the union. The management had been unsuccessful in sustaining improvements in patient satisfaction using more traditional approaches. Management also hoped that relying more on front-line staff would improve staff satisfaction, which remained stuck at an unacceptably low level despite numerous efforts to make improvements.

The union saw in this approach a way to get more of its members actively engaged. Like most local unions, the WFNHP chapter at St. Francis spends most of its time on contract administration within the hospital and political action outside the hospital. But that only directly involves a small percentage of its members. In fact, research suggests that, on average, only around 2 percent of union members file a grievance in any particular year. And only one-third of members ever file a grievance. The union was actively looking for ways to deliver value to a bigger swath of its members. Mobilizing members to make improvements in patient care offered a particularly attractive way to do that, since it taps into the biggest drivers of staff satisfaction – having a voice in decisions that affect how work gets done and providing better care to patients.

There were several factors that made St. Francis a good site for this experiment. The hospital's financial situation was relatively stable, after a turbulent period of cost cutting a couple years before. Most of the management team was new, having arrived after the cost cutting had taken place, and they were focused on expansion and growth, not survival. There was a positive relationship between the union and management, who freely admitted that they had not been able to make the improvements that they needed on their own.

The project ended up focusing on the Emergency Department (ED), in part because of its strategic importance. More than half of all patients admitted to St. Francis come through the ED, and an even greater number of people from the community are treated there, and through their experience, form an opinion about the quality of care the hospital provided. As a result, much of the hospital's reputation in the community hinges on what happens in the ED.

Fortunately, the ED already had a great reputation to build on, having been cited as one of the top 5 percent in the US in providing high-quality care. There was also a committed, dedicated staff in the ED that got along well with each other. In addition, there was a committee already in place to lead this effort, the RN/MD Committee, which had experience working together to make improvements. That committee was expanded to include ED Techs for this project to make it more broadly representative.

The existing Labor-Management Committee, whose membership included top leadership from both the union and management, provided oversight to the project. In addition, an outside consultant experienced in labor-management committees and hospital improvement efforts, and staff from the AFT and the Wheaton Franciscan Healthcare System, supported the project.

Transport Project

In August 2010, members of the RN/MD Committee surveyed staff and managers in the ED to identify “What is the biggest obstacle to consistently delivering the highest quality

care in the ED?” The responses focused on seven key issues. The issue they selected to start with is:

“How can we transport patients more efficiently from the ED to procedures and to the floor without pulling staff away from other more important responsibilities?”

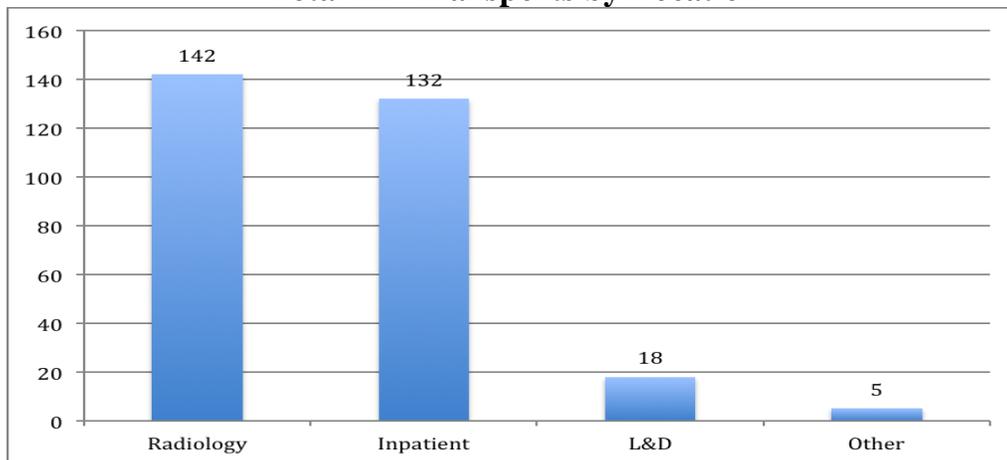
Members of the committee chose this issue because of its potential to improve patient satisfaction by reducing wait times, and because of its potential to improve staff satisfaction by freeing up time to address other high-priority issues identified in the survey responses.

To get a better handle on what was actually breaking down in the transport process, ED staff collected data for a two-week period in late September and early October to determine:

- How often do ED patients require transport to and/or from another department?
- Are there particular times of the day or particular days of the week that are busier than others?
- How much time do ED staff spend out of the ED transporting patients?
- Which ED staff are most involved in providing transport?

The data collected by ED staff suggested that over 90 percent of transports were for ED patients being admitted to the hospital or for ED patients that required CT scans. Of those, roughly half were to inpatient floors and the other half were to Radiology.

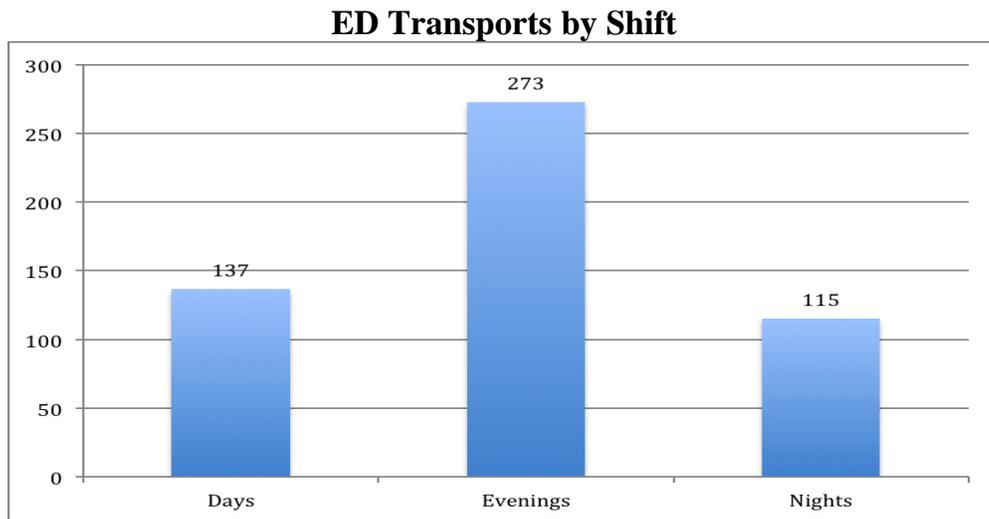
Total ED Transports by Location



As a reality check on the data collected by ED staff, those data were supplemented by hospital data showing the actual number of ED patients admitted to the hospital during the same two-week period, as well as the actual number of ED patients that required transport to the Radiology Department. The hospital data showed that, on average, 36

patients a day required transport from the ED to Radiology or to an inpatient floor. The data collected by ED staff showed that an additional 4 patients a day, on average, required transport from the ED to other areas of the hospital, primarily Labor and Delivery. The ED data also showed that 5 patients a day, on average, required transport to the ED from another area of the hospital by ED staff. That added up to an average of 45 transports per day.

The hospital data suggested that half of these transports occurred on the evening shift, and that the other half was split between the other two shifts. There did not appear to be any particular pattern regarding days of the week.

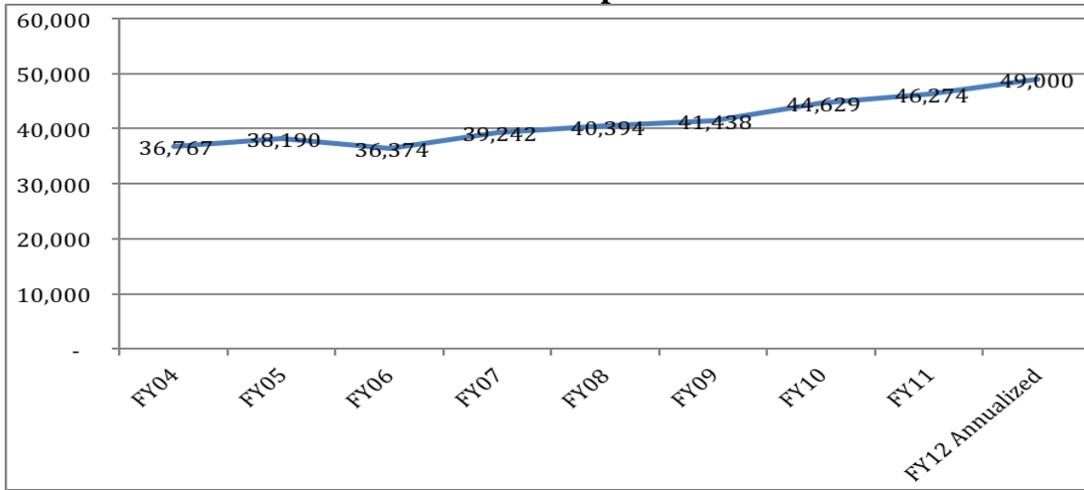


Data collected by ED staff suggested that each transport took 12 minutes, on average. Therefore, ED staff were spending roughly 9 hours per day transporting patients (12 minutes/transport x 45 transports/day). For the most part, this burden fell on the ED Techs, except for on nights, where it was shared by RNs.

The committee looked at using the hospital-wide transport service to help with all or part of these transports. However, hospital-wide transport staff were not available to handle this load, nor was the hospital-wide transport system designed to consistently meet the needs of the ED for a quick response time. In fact, when staffing levels were set for the hospital-wide transport service a year and a half earlier, ED patients were not included in the needs assessment. As a result, that service was eliminated on the second shift, when demand is greatest in the ED.

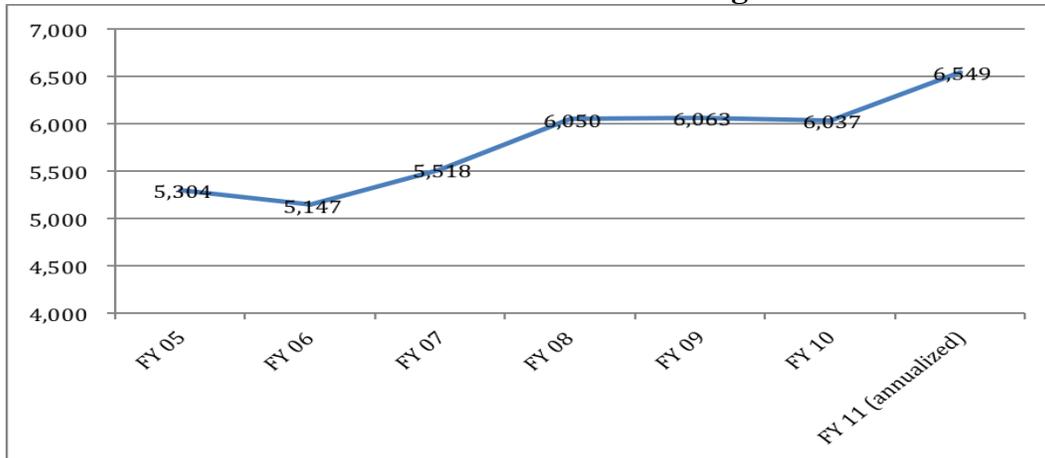
At an earlier time, it may have been possible for the ED to handle patient transports on its own. However, the volume of patients in the ED had increased significantly over the previous 5 years, and was expected to continue to increase as health insurance coverage expanded and primary physicians continued to be in short supply.

Total ED Visits per Year



The RN/MD Committee met with the hospital’s executive team to explore ways to address this problem. Based on the data that had been collected, they agreed that the hospital-wide transport staff should be increased by 2 FTEs dedicated to the ED during peak times. Those additional transport staff would free up ED staff to spend more time with patients, and to work on other improvements, such as making sure that the right supplies were in the right rooms at the right times, getting an earlier start on and being more timely in testing new patients, and developing a more cohesive multi-disciplinary team in the ED. In addition, they agreed that the next CT scanner would be located in the ED to keep up with the rising demand, and the hospital would explore options to accelerate the purchase of that equipment.

Total Number of ED Patients Receiving CT Scans

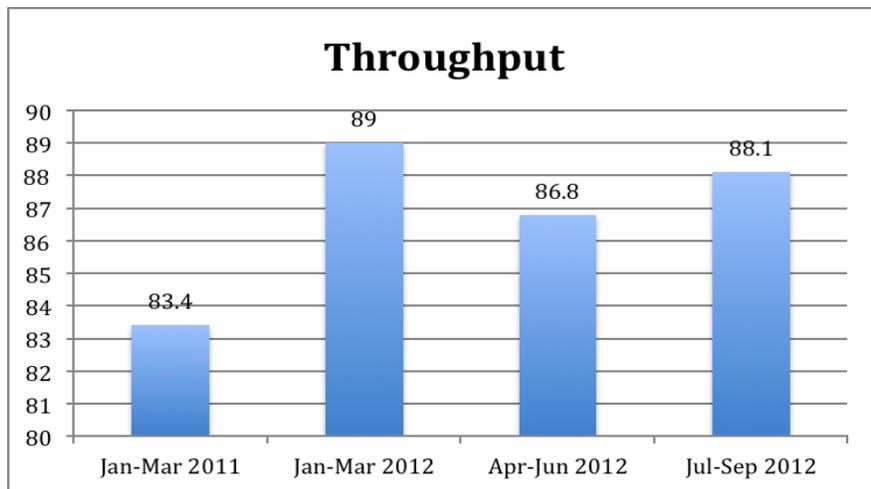


As part of this agreement, however, the executive team required that the RN/MD Committee track patient satisfaction, throughput, and employee satisfaction to determine whether the additional transport staff actually made a difference in performance. Systems were already in place to track patient satisfaction and throughput, but not

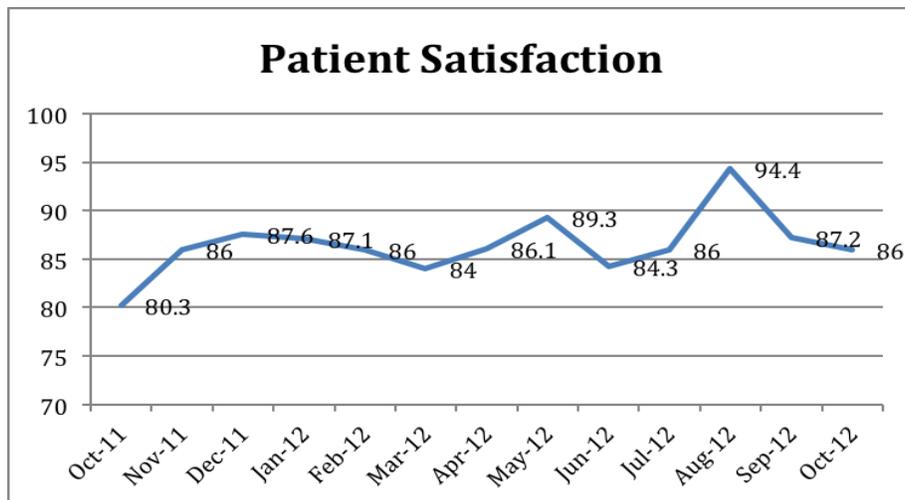
employee satisfaction. So, the RN/MD Committee developed and conducted its own survey of ED staff satisfaction to establish a baseline, with plans repeat the survey on a regular basis to track progress.

Outcomes

It took several months to get the additional transport staff in place. However, once that happened in November 2011 there were noticeable improvements in throughput, measured as a percentage of times that ED patients are discharged from the ED within 60 minutes of when a bed is assigned. There was a 6.6 percent increase in throughput in the first 4 months of 2012 over the same period the previous year. And that higher level of performance has been sustained through 2012.



Similarly, patient satisfaction scores, as measured by overall satisfaction with experience in the ED, have improved significantly, boosting the ED from the 30th percentile to the 75th percentile when ranked against other institutions across the US.



The hospital has followed through on its commitment to acquire a CT scanner for the ED, which will dramatically reduce the need for transporting patients to Radiology. That should lead to further improvements in throughput and patient satisfaction not reflected in these numbers.

There has been no survey of staff satisfaction since the additional transport staff were put in place, so it's not clear yet what the impact has been on that measure. However, in a follow-up meeting with ED staff, they reported that there are no longer any complaints about the rooms being stocked properly, since ED Techs now have more time to spend restocking. In addition, staff report that things seem to be running more smoothly in the department in general.

Another outcome of this project is that the RN/MD Committee has continued to take on other issues that affect patient and staff satisfaction in the ED. Following the transport project, they identified the next big issue as making sure that translators are more available when needed to better serve the growing number of non-English speaking patients that are being seen in the ED. Using the same methodology as the transport project, they gathered data on how many patients required translators, when the demand was greatest, and how long it took for help to arrive.

They reviewed the data with the Interpretive Services director for the Wheaton Franciscan Healthcare system, who agreed to expand the hours of coverage in the ED, dedicate translators to the ED during high-volume periods, and put translator phones in every ED room. Staff report that these changes have made a significant difference in their ability to respond to the needs of non-English speaking patients, who represent a growing share of the volume in the ED at St. Francis.

Following the interpretive services project, the RN/MD Committee decided to take on the issue of workplace violence to reduce disruptive patient and visitor behavior. Again, using the same methodology as the transport project, the committee surveyed ED staff to determine the type and frequency of such incidents, how they were being dealt with, and what could be done to improve the situation. The ED staff has been working with the hospital's security staff to implement new procedures.

Another interesting outcome of this project is that the MDs involved in the RN/MD Committee have advocated that the seven other hospitals they work in take a similar approach to improving patient care and satisfaction.

Conclusion

These outcomes suggest that relying on front-line staff to make improvements in patient care and patient satisfaction holds promise for more significant and more sustainable

improvements than the usual top-down approach. However, this was a relatively small experiment that lasted only a few months. This approach would need to be applied on a larger scale over several years to realize its full benefits.

For St. Francis, those benefits would include documented proof that the quality of its care is superior to the care of its competitors. For the union, those benefits would include documented proof that only unionized hospital in the system (and in the market) can provide higher quality care than non-union hospitals. However, realizing those benefits would require persistent and patient leadership on the part of both.