OP-21: Median Time to Pain Management for Long Bone Fracture

atom Alliance Workgroup Sharing Call

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Welcome and Introduction

Welcome to the atom Alliance workgroup sharing call entitled OP-21, Median Time to Pain Management for long Bone Fracture. I will be facilitating the session today. I work with atom Alliance and I will be your event moderator.

Our agenda today include some opening remarks, a few housekeeping items, the presentation on OP-21 and interactive case study challenges, a summary on what was covered, some time to open the lines and share with your peers, a question and answer session and closing remarks.

atom Alliance is a five-year, five-state initiative with powerful sustainable change in healthcare quality. We welcome participants from Alabama, Indiana, Kentucky, Mississippi and Alabama, as well as other states that maybe participating. Thank you for taking the time to join us. We appreciate all you do to improve quality and achieve better outcomes in health and healthcare and lower costs for the patient the communities we serve.

Here are the objectives for today's webinar. After participating today, you will better understand OP-21- median time to pain management for long-bone fractures, successfully lower the time to pain management, the use of best practices, share and learn current best practices and interventions, spread best practices from your peer organizations across the five-state alliance, recognized expertise and inventiveness that can be found in each facility.

Please standby for real time captions.

Housekeeping

Before we begin, I want to run through a few housekeeping items. All the lines have been placed on mute during the presentation. We will enable the ability for you to take your phones off commute so that you can share with the group. You may use *2 to take your phones off mute and *9 to raise your hand during the presentation if you would like your phone to be taking off of mute to participate.
We encourage your participation throughout in the chat feature. You can submit questions or comments to all participants or set individuals from the drop-down menu. Patty Brinkley and Margie Banse from the atom Alliance will be monitoring for questions or feedback you would like to share and will respond in the chat box or during the call. You may also download the slides which will be posted in the chat. You may also use a Q&A function to direct your questions to certain individuals privately throughout the presentation.

During today's presentation, we are aiming for 100% participation in our interactive case study challenge questions by using the polling feature. Please do not be afraid, all answers are anonymous. The questions will come up on the right-hand side of your screen in the polling area. Right after you have selected your final answer, please be sure to hit the submit button so that we can capture your answer.

**Presenter Introduction**

At this time, I would like to introduce to our speaker, Justin Young. Justin is a Registered Nurse with a strong clinical and education background. He served as the Emergency Department shift leader, where he was responsible for managing and overseeing clinical support staff to ensure the highest level of staff to critically ill patients. In addition to his clinical experience, he served as Clinical Informatics Coordinator and he was responsible for education of healthcare staff, technology and the development of evidence-based interventions and protocol. Today, Justin has been a Quality Improvement Advisor for atom Alliance in support of a geographic community of healthcare providers working collaboratively to deploy evidence-based interventions to reduce unnecessary admissions to hospitals in Tennessee, including Medicare beneficiaries and improved transition of care between healthcare settings and reduce adverse drug events. Justin, the floor is all yours.

Thank you. I appreciate it and I wanted to say welcome and thank you everyone for attending today. For our webinar and four the OP-21 Median Time to Pain Management for Long Bone Fractures.

**Background**

Before we get started, I want to give a little opioid disclaimer. There is an opioid epidemic and we are not advocated for the use of opioids. The most important thing is to effectively minimize pain experienced by the patient by continuing to give timely pain medication to appropriate patients. This statement comes from the CMS’s website and it says the mission of the CMS opioid misuse strategy is to impact the national opioid misuse epidemic by combating nonmedical use of perception opioids, opioid use disorder, and overdose that the promotion of safe and appropriate opioid utilization,
improved access to treatment for opioid use disorders, and evidence-based practices for acute and chronic pain management.

Defining OP-21

A little background into this measure. OP-21 Median Time to Pain Management for Long Bone Fracture became in outpatient reporting core measure in January 2012 and it is a process measure. It is measured by the median, not the mean. Of course, the lower the time that is recorded, the better.

The description from the Spec manual says the median time for emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a principal diagnosis of a long bone fracture.

The rationale behind this, this also comes from the spec manual is based off of numerous studies examining the undertreatment of pain management and emergency departments as well as studies that show improvement in performance measures when these are implemented.

Long Bone Fractures

What is a long bone? Long bones are hard, dense bones that provide strength, structure and mobility, to support the weight of the body and facilitate movement. They are mostly located in the appendicular skeleton and include bones in the lower limb, tibia, fibula, femur, metatarsals and phalanges and the bones in the upper limb, metacarpals and phalanges.

Symptoms of a bone fracture include swelling or bruising over the bone, deformity of an arm or a leg, pain in the injured area that gets worse when the area is moved or pressure is applied, loss of function in the injured area, and the most obvious compound fractures have bones protruding from the skin.

Measure Inclusions

Now that we know a little background into long bones and the symptoms for those, we are going to get into who is included in this measure. Patients that are greater than two years old with a principal diagnosis code for Long bone fractures that are discharged or transferred from the ED. It includes patients from age 2 to 17 years, 364 days old and they are given oral, intranasal, IM or IV medications, conscious sedation or nerve block or hematoma block in the emergency department. For ages 18, patient 18 years a greater that are given the same list but intranasal, IM, IV medications, conscious sedation or nerve block or hematoma block in the emergency department in the patients given oral medications first are excluded from the measure.
Who is excluded? Patient less than two years old, patients who are expired, patients who left the emergency department against medical advice or discontinued care, no pain medication was given in the ED, the patient is admitted, pain medication including Tylenol or Motrin given prior to arrival or taken on a regular basis in patients of any age. For patients greater than or equal to 18 years old, the first dose of pain medication is an oral pain medication. Something else that should be added to the bottom of this list is any documented patient refusal, but it would have to be documented within the chart.

Scoring by State

Now that we have the inclusion and exclusion criteria, how do we score by state? We see median times of 47 minutes to 60 minutes to treat these painful fractures and these are reported in various hospital meetings on various reporting websites, such as hospital compare and that is where this data was pulled from.

Interactive Case Studies

Patient #1

Why does it take so long to receive pain management for long bone fractures? Are several barriers that affect the administration of pain management for patients of long bone fractures. Some include long ED wait times, door to physician times, long radiology result times as well as others. Take a look at some case studies to get a better understanding of how the median time is calculated.

For the next interactive section, please use the WebEx polling feature to the right of your screen and remember to click the submit button and do not be afraid because all of your answers are anonymous. What time is calculated for this patient?

A 37-year-old construction worker suffers an open fracture of his left femur on the jobsite. He has severe pain and is given 100 µg of Fentanyl by EMS. In the emergency department, he continues to have severe pain and is giving multiple doses of Dilaudid with the first dose given five minutes after arrival.

Please use the polling feature to your right to participate in do not forget to click submit. The answers are, possible answers are what time is calculated time to pain management for patient number one? Five minutes, 15 minutes, excluded or unknown or not enough information? Don't forget to click submit once you enter your answer. Take just one moment to calculate. Five minutes, 15 minutes, excluded or unknown or not enough information?

It looks like the majority of the people chose five minutes and the majority chose excluded. Justin?
Very good. The patient is excluded. He is excluded from the calculation having been given medication prior to arrival. Any medication given prior to arrival, including oral medication, would exclude the patient from the measure and that includes scheduled doses as well.

Patient #2
We will move to patient number two. What time is calculated for this patient? An 83-year-old woman suffers a ground-level fall at home and injured her right hip. No medications are given by the EMS due to concern of altering the patient's mental status. However, morphine is given in the emergency department two minutes after arrival. X-ray result show the patient to have a hip fracture and she is admitted for surgery.

Once again, don't forget once you make your choice to click submit. The possible choices are what time is calculated. Two minutes, 20 minutes, excluded or unknown or not enough information?

That is two minutes, 20 minutes, excluded or not enough information. It looks like we have a mixed bag. The majority say two minutes and the next is excluded and not enough information. Justin?

That one was a little tricky. This patient is also excluded. OP-21 is an outpatient measure and OP stands for outpatient, which only includes patients who are discharged or transferred. But they did give appropriate care within two minutes, with this patient being admitted excludes them from the measure.

Patient #3
What time is calculated for this patient? An 11-year-old female presents to the emergency department with right wrist pain after a fall, three days prior to arrival. Parents have not been giving pain medication at home because they report she has been relatively painless and they are only in the ED due to wrist swelling and some trouble writing at school. Wrist x-ray comes back after one and a half hours showing a buckle fracture. The wrist is splinted and the parents, now feeling guilty, ask for a dose of Tylenol prior to leaving. Tylenol is given two hours after arrival to the emergency department.

Once again, don't forget to click submit. The possible choices are 90 minutes, 120 minutes, excluded, unknown or not enough information. Again, the choices are 90 minutes, 120 minutes, excluded and unknown or not enough information.

Will take just a minute to calculate. Is looks like the majority set up 120 minutes. Justin?
You guys are getting good. This patient has a long bone fracture, no pain medication was given at home, the first pain medication was given at 120 minutes after the arrival to the emergency department. That is correct, 120 minutes.

Patient #4

What time is calculated for this patient? A 44-year-old male checks into the emergency department with the complaints of left hand pain after becoming frustrated over a do-it-yourself home project gone wrong and punching a wall. He is given an ice pack and taken to an exam room. The patient is found to have a Boxer's fracture of the fourth metacarpal on x-ray. The patient receives 30 mg IM Toradol 1 1/2 hours after arrival.

First, let me say, it is never a good idea to punch a wall, but okay. Don't forget to click submit. Here are your choices. Five minutes, 90 minutes, excluded, unknown or not enough information. Again, your choices are, five minutes, 90 minutes, excluded, unknown or not enough information? It is calculating. The majority think 90 minutes. Justin?

Right on the money. This patient has a long bone fracture and no pain medication was given at home. The first pain medication given is 90 minutes after arrival to the emergency department.

Patient #5

Patient number five. A 55-year-old patient falls injuring his wrist, which has an obvious deformity. He doesn't want pain medication as he says it doesn't hurt if not moved. The physician writes in the record that the patient is not in pain and doesn't get the patient pain medication. The nurse rights in the medical record the pain is zero out of 10. The x-ray shows a Colle's Fracture that will require reduction. Reduction is set up including finger traps, split etc. and a hematoma block is given two hours and 10 minutes after arrival.

Once again don't forget to click submit once you choose and your choices are, 130 minutes, 180 minutes, excluded, unknown or not enough information. Your choices are 130 minutes, 180 minutes, excluded or unknown or not enough information. We'll take a few seconds to calculate. Looks like a tossup from 130 minutes and excluded. Justin?

This one was tricky. I can see where people would say excluded because they are thinking that the patient would be admitted, but 130 minutes. The hematoma block is considered pain medication and is the first given to the patient after he arrived. However, if the nurse or physician would have documented initial refusal of pain medication, the patient would have been excluded from the measure, but there were no specific statements, only documentations of no pain and the patient is included.
Summary
Lessons Learned

We will move on to lessons learned. Examples showed the challenges of the measure event the patient above, most may think that the hospital did an appropriate job of pain control and Hospital Compare would show the time as 120 minutes for this hospital. You can see how that is the median and not mean that would give you 120 minutes. We also put on here the statement from hospital compare a people that of which is sort of misleading in a way we think about the measures and things that the hospital did to try to satisfy the patient. It is the average median time patients who came to the emergency department with broken bones had to wait before getting pain medication which does not include the patients that were excluded from the measure.

Inclusion and Exclusion Guidance

Some rules to follow. Again, the slide we had earlier but I wanted to drive these homes. Patients greater than two years old with a principal diagnosis code for long bone fractures that are discharged or transferred from the emergency department are included in the measure. These are patients between age two and 17 years, 364 days old, and they are given oral, intranasal, IM or I've education, conscious sedation or any nerve block or hematoma block in the emergency department. For patient 18 and greater, has the same list, but the patient that are given oral are excluded.

Excluded patients include patients less than two years old, patients who expired, patients who let the emergency department against medical advice or discontinued care, the patient that is admitted, no pain medication given in the emergency department, pain medication including oral, Tylenol or Motrin, given prior to arrival or taken on a regular basis in a patient of any age, and for patients greater than 18 or equal to, the first dose of pain medication is oral. They are excluded. Also on this list as mentioned earlier, documented refusal of pain medication would also exclude them.

Here is the same information broken up a little bit differently in a graph form. These are patient aged 2 to 17 and 364 days old. The exclusion for the hospital if they take regular pain medication or took an acute pain medication, they are excluded. In the emergency department, the patient where no pain medication was given through any route are excluded from the measure or if they give a specific statement of pain medication refusal that is documented, they are excluded. Also, any patient that is admitted is excluded from the measure. Patients that are included, no prehospital pain medication of any route and in the emergency department, time to first pain medication is in the measure. Those include the PO or at this age group and the patients that are also included in the measure are any patients discharged home or transferred to another facility. Here is another
graphic that shows patients 18 and greater. Excluded from any pain medication given, PO, IV, IM or intranasal, either chronic or for an acute episode. They are excluded from the measure if no pain medication was given in the emergency department. They are excluded from the measure if the first dose of pain medicine was oral or if they have specific statement of pain medication refusal documented in the chart. Also, patients that are admitted.

Included patients for patients that do not have prehospital pain medication by any route. Time to first pain medicine, as long as it is IM, IV or intranasal medicine for the first dose, and the patients are discharged home or transferred.

**Sharing**

Tips for success. Most important is to effectively minimize pain experienced by patients by continuing to get timely pain medications to appropriate patients. Things that can be useful is a triage order set or protocol that ensures everyone receives an oral dose of medication for a potential long bone fractures may greatly improve pain management times. This might exclude patients 18 and greater, it might be good to get them something for their pain before it becomes 60 minutes a longer. Patients with any document to pain medication prior to the emergency department are excluded, and that includes even oral medications. You have to make sure if it is written in red that it is documented in the charts. If the pain medication patient refuses pain medication initially, you need to document that statement in the chart at the times of the patient can be excluded as well. Patients given oral more oral medication first in the ED are excluded and patients who are admitted are excluded.

Here are some of the references were some of the information came from CMS, Medicare, QualityNet and a lot of the case study slides are based on these slides here.

**Question about Patient #4**

At this time, we are going to open up for some questions. Do we have any questions that came in in chat while we were going through?

We did. This is Margie. Karen asked a question about patient number four. Question is, did you check his home meds? Did you address that?

It was not addressed on the case study, but that would be something that you would look for. Any time there is a scheduled pain medication or something that would exclude the patient in triage you would look for that first thing with medication. You would check that and if it was something that was a regular dose medicine, that would exclude the patient from the measure. That is a good question.
Do we have any more?

At this time, I do not see any more questions in the chat box. Please feel free to add those in in the chat box on the right if there are any questions and don’t want to speak up.

Question on Benchmarks
I'm sorry. I made that statement and all of a sudden, we had two more come in. There's a question from Courtney. What is the benchmark?

Let’s see, if I could find it really fast. For the national average, it is at 52 minutes. Depending on state, those range from 47 minutes to 60 minutes. On the scoring for that median time. I think the most important factor to remember is to try to lower that number as much as we can. Even if you are within the national average of below 52 minutes or below a state average of 47 minutes or 60 minutes, we just have to remember that these things are painful and the biggest priority is to effectively treat pain in these patients. I think the benchmark would be below those national and state averages, but we definitely need to have the focus on reducing those as much as possible.

A follow-up question, from Lesley. Is that meaning only inpatient status or is observation status excluded as well?

I don't know the answer. I will have to look into this question. Observation, I'm not sure as far as admitting somebody usually when you get a minute to the hospital for a bone fracture it is because it will require surgery. It is not to watch it like you would a chest pain or something. With the two-midnight rule, I'm not positive on that but I would almost say if they are saying an item hospital that would count as an admission but I will double check on that. Leslie, if you will send your email assuming a message with your email I will follow up on that. I don't see that there are that many people that are having to observe them for a break.

Request for Peer Sharing
If you guys have questions or if you would like to talk about in order set or protocol that you have in your facility or a strategy for provider and triage or team triage methods, or something else, because this is a process measure, I know that those are very important. The door to provider time ultimately is what will lower these scores. If you have some we will on the airline tickets your questions.

I just wanted to share that they have had observation patients that had actually have fallen into the measure, so perhaps that is something to add to your research.

Okay.
Protocol to Reduce Time

This is We just took the phone also to mute of someone calling in from and 812 area code who have raised their hand.

This is Kathy Wickman from Scheck Medical Center in Indiana. We have what we do is we have some fairly outstanding protocols in place that we implemented a while back to address making sure our patients are getting the appropriate pain medication for their injury in a timely manner. We have had to work with EMS to make sure their protocol is in order, they are their own entity, but we collaborate with them well and are able to identify some long bone fractures in the field and they premedicate patients to get patients with any. The triage protocol is such that for patients 18 and older, who meets the symptoms are based on the triage assessment obviously we are going to assess further pain and we are going to administer from pain medication to them. Is that isn’t going to meet their pain management needs, then we will have a face-to-face conversation with the provider and get them something more. Currently, right now, our door to Doctor times are at about 12 minutes and our long bone fracture time is 21 minutes. We feel like our process, we have, is well-established and we had a lot of buy-in from our staff to make sure these patients are getting what they need. We work with radiology also to have a communications system in place so that they know when our patients are ready to get over to x-ray because we want to make sure we medicate them first, just so that does not delay our time. We want to make sure we are giving the patient's pain met immediately.

That is fantastic. 21 minutes is a great time and your door to Doctor time is excellent as well. Thank you for sharing that. Let me ask you this. On your order set, what kind of pain medication are you using for that? Is it Tylenol or ibuprofen that is kind of the standing orders for triage?

They are. Is specifically for long bone. It is Tylenol and ibuprofen. In the event it will require an IV medication or a different kind of PO medication that is when we will have the immediate face-to-face conversation to take a verbal order from the provider. We present our case and say we triage a patient, we believe they have a longer bone fracture that the pain is out of control of like to give them something beyond Tylenol. Obviously, we have done a good triage assessment of the patient, so we know what the allergies are, and we talk with the doctor at that time.

Will add that we have had a lot of buy-in from our ER providers. We have MDs, DOs, NPs and PAs. With great buy-in from all disciplines, we have been able to significantly lower the number.
That is fantastic. It definitely takes the buy-in and education of staff to meet these measures, especially the process measures which are a little bit different than some of the other ones. That is fantastic.

Just a point I like the way you worked with other facilities that use these orders that's and administer Tylenol or ibuprofen for that and excluding is not a bad thing. It will actually not help or hurt, but getting them in their as opposed to waiting for radiology results that it turns out to be a good thing to exclude some of these patients from the measure even though you guys are reassessing for pain, which is important as well.

I think for us, when we initiated this protocol versus some others that we had consider, our most important thing was to treat the patient’s pain. Whether it is broken or not broken, if you are assessing the patient's pain early on and treating that, that is the best thing for the patient. When we think about long-term for the patient's and even short-term for the patient, we want to do the least invasive work of the easiest route for the patient which is to not be stuck with a shot or an IV stick, so if we can meet their pain needs for peer medication even if it doesn't exclude them. Who knows what our time would be because we are really fast with that. Getting the PO med administer. For us, it was more important that they got the right medication for the right pain level. We simply will not go the route of immediately jumping into another type of pain protocol for it is and that is similar to point. When you mentioned the part about excluding those patients that would be even lower the average median time for patients who enter into the emergency departments and wait for a long time, it doesn't show in the numbers, but you guys are doing the right thing and it is ultimately the most important part is taking care of the patient. Thank you for sharing with us.

Thank you.

Question on Patients Denying Meds

We had another question come in for clarification in the chat. Is a patient that has a long bone fracture that denies pain and this is documented, is this patient included or excluded if the patient stated they deny pain, is that enough?

It really needs to be stated that the patient declined the pain medication. Having said they are decline in the medication. If they are saying they have not measure something is being offered to the patient then these order sets that offer ibuprofen or Tylenol, ultimately probably need to have something in there to say they are denying the pain medication rather than saying I am not having any pain at this time. It need to state no pain medication. One of the case studies we went through, the Doctor documented not pain at this time and the nurse documented 0 of 10, that patient was specifically denied declined the pain medications that they were excluded from the measure.
You are on.

To further clarify what we did with that is, if the patient refuses it go ahead and order an oral medication and write the patient refused, so that it is well-documented.

I think that is probably the best step.

Time Reduction Efforts
We have somebody who would like to share. I will take your phone off mute now.

This is Michelle, Karen and Lacey from Marshall Medical in Lewisburg Tennessee. We were listening to the protocols that were implemented over at Indiana and there are definitely a lot of similarities and really like the idea of getting EMS involved. That was one piece we had not thought about because we also do not own our EMS here. I'm definitely going to follow up with that. The only additions I have so what we are doing here is we have put some visual prompts in place to remind the staff. As far as physicians, we've got some physician by hand, some physician reluctance. We're working on that and the other thing is that if I am auditing a chart or when we get the data to submit and we find that there is a fallout, I am addressing the nurse of record not as punitive, but make it more of a teaching moment. To me about this case. Do you remember? Why did it's the patient get medicated or why was there a delayed medication? Sometimes went reading the chart it doesn't always say everything and lots of times it is exactly what you said. The patient may have refused the initial doses of medicine and they have nothing documented to the record in the next thing you know he is getting an IM shot of something and that is what you have to include. That was just my inputs and thank you for sharing.

Thank you for stepping up to share that. You cut your time almost in half by implementing the order set. Is that correct?

Absolutely. I think we are running right around 40 minutes compared to what we were and we're working on getting it down to that 20 minutes or 30 minutes for the 90th percentile, that is our goal.

Care Team Approach
Next, we have Helen from Johnson County.

Hello, Helen.

Hello. Are you?

Doing well. I was making sure you could hear me. I'm at the Johnson County Community Hospital in Mountain City, Tennessee and one of the things we have done is set up a care
team approach. We get the triage room and patients are brought straight back to the ED and the nurse and doctor both, as much as they can, get into see the patient at the same time they come through. The other thing they would have done is set up standing orders so that if for some reason that Doctor cannot get in right away but go ahead and medicate the patient. We have done well and at this point we are the year started with our fiscal year, which started in July. We are at 34.6 minutes. In April, we were at 28 and in May we were 20. We felt like we may not be as good as some other people we still think that is good results.

Absolutely. You guys have the Johnson County is one of our smaller Critical Access Hospitals here in Tennessee. But you had for your triage approach is a little different that your door to Doctor time is excellent. I cannot remember right offhand what it is but with this process measures that is one of the most important things to either get the orders that you can implement immediately or having that door to Doctor time the as short as possible. If you wanted to speak about that.

The care team approach is what did that to get the door to Doctor team down, which is on the care team who is involved with that?

The physician and the nurse. And sometimes two nurses, if they are both available. We will double-team them and get everything done.

Very good. Does anybody or did you have a strategy where you tie in radiology just so that those I know that now that time you are getting radiology results they probably should have already had a pain medication. But is there anything you do or any kind of strategy that you involve radiology in the process of trying to get the results back to expedite the process so that you don't have to go to the room will take you to get your x-ray?

Have them come to the room, if it is possible to do it. Otherwise will take them back, but we do have standing orders that allow us to go ahead and get those x-rays ordered if the physician is not immediately there.

Okay. I think that is important too on the standing orders to have something like that you can expedite the process with ordering the x-rays. Thank you so much. I appreciate that.

Starting at Registration

Somebody from Indiana. Hello? This is Karen Hester from Terre Haute Regional Hospital in Terre Haute Indiana. Our ER team is unable to be on the call today because they are in staffing, so I'm in Quality and I'm going to speak to our process. When we have a patient that walks in our it starts at the registration desk. They have had an injury to an extremity or whatnot those patients which try to get them triaged as fast as we can
and the registration person radios to the nursing staff to come bring them back. Once the nursing staff and triaged confirm that the patient does have a possible fracture the physician gives orders -- which is a huge improvement about two years ago we're beating our heads trying to figure out how to decrease our time. We do not have standing protocol. The physicians want to be the ones to address the pain medication and not necessarily have a standing protocol, so we have is a workflow process where we alert nursing a position as much as possible. We do try to in most cases give pain management before the patient is taken to x-ray, because we have had a few misses because the patient was whisked off to x-ray first. Our workflow process is a lot of communication. Excellent. Sounds like you guys do a good job of educating staff as well, which is important in any of these measures to understand why they are doing what they are doing.

Thank you.

Do have any more questions or would you want to share something useful that you are using within your facility that you think someone else might like to do or maybe a barrier that you need to discuss? We have several facilities on the call and we may be able to help if you need that.

Immediate Assistance

This is Cathy from Indiana. A different approach from another hospital in Indiana, which is Major hospital, I know that one of the Tennessee hospitals talked about no longer triaging or immediate betting. I know that Major Hospital also does that. Is Crystal on the line to talk about that, from Major Hospital?

She would probably have to press *9 or *2 to unmute. This is Crystal, from Major in Shelbyville. Can you hear me?

Yes, we can hear you.

Yes.

Basically, I listened to Kathy down from Seymour and I just reiterate everything they are implementing and putting into place. I guess, lucky for us, not everybody has the ability to switch physician groups, that actually increased our door to Doctor time and helped this measurement. We actually switched physician groups back in 2013. So, all of 2014, we have the buying and now with our new physician groups than we ever did with our old group. That obviously was a big win-win for us. They also wanted to implement no triage and we immediate bed. We don't have patient who wait in the waiting room.

Another thing is I know you have nurse practitioners or PA's that assess the patient, sometimes for the nurse does.
That is correct.

I think that helps too with the immediate assessment.

Yes. I definitely agree with that.

That is good. Also, most excited about having them address and decrease the ED wait time for check-in to have to sit in the waiting room, which is very huge for this measure. In this process measures, that you could get the treatment started from the moment they come into the door, which will definitely benefit the patient. I give kudos to Indiana as well. They had the lowest scores in our five states, 47 minutes. They are definitely onto something and have some really good strategies for meeting this measure.

**Closing**

Do we have anybody else would like to share or ask any questions or have suggestions for physician buy-in or other barriers when trying to meet these goals to lower your times?

No other hands are raised at this time.

I will give it just another minute and then I will turn it over Lynn.

I want to say thank you and will turn it over to discuss some of the online demand learning.

Thank you to our speaker, Justin Young and thank you all for joining the call today. The atom Alliance staff is here to help. Please go free to contact us if you have any questions about what you have just heard or need technical assistance with improvement initiatives. Also, please take a few moments to complete the post-event survey. Your feedback is valuable to us and will help shape future learning and action network events. Just a reminder that this call was recorded and the recording and transcripts will be posted on the atomAlliance.org website. You can also check our past presentations under the on-demand learning section. Lastly, please connect with us on social media so that we can continue to share and grow this network and demonstrate the impact of the work we're all doing to improve the quality of healthcare. Please like, tweet, connect with us or pin us. Thank you again for your participation and have a great afternoon.

[Event Concluded]