The Psychology of Waiting

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Goals

▼ An understanding of the psychology involved in waiting

▼ What's useful for us in our practices

▼ How can we apply the observations on the psychology of waiting and benefit from them

▼ Let's have some fun with this…

ED Service Operations

- ▼ Systems thinking and appreciation-A system is a network of components which work together to try to achieve common aims

- ▼ A theory of knowledge- You need a theory of knowledge about your system-an understanding of your ED, your hospital, and your processes

- ▼ Get clear about the key drivers of system performance:
  - ▼ Demand-capacity management
  - ▼ Queuing
  - ▼ Variation

- ▼ Define the high-leverage interventions:
  - ▼ Theory of Constraints

- ▼ Deploy a method or system for improvement: Lean, Six Sigma, TQM…

- ▼ Where waiting exists-apply *The Psychology of Waiting Lines*

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Leisure Trumps Learning in Time-Use Survey

Americans Opt for TV in Spare Hours, Not Workouts or Classes, Poll Finds

Eating and drinking
1h 12m ▲ UP 1 MIN.

▲ **CHANGE SINCE 2007**
▼ (pre-recession)

Sleeping
8 hours 23 minutes
▲ UP 5 MINS.

Watching television
2h 31m ▲ UP 5 MINS.

Household activities
1h 41m
▼ DOWN 1 MIN.

Caring for household members
32m ▼ DOWN 2 MINS.

Organizational, civic, and religious activities
16m UNCH.

Caring for nonhousehold members
12m ▲ UP 1 MIN.

Work and work-related activities
4h 24m
▼ DOWN 25 MINS.

Other activities
21m UP 10 MINS.

Personal care
49m
▲ UP 3 MINS.

Purchasing goods and services
43m
▼ DOWN 2 MINS.

Education
36m
▲ UP 4 MINS.

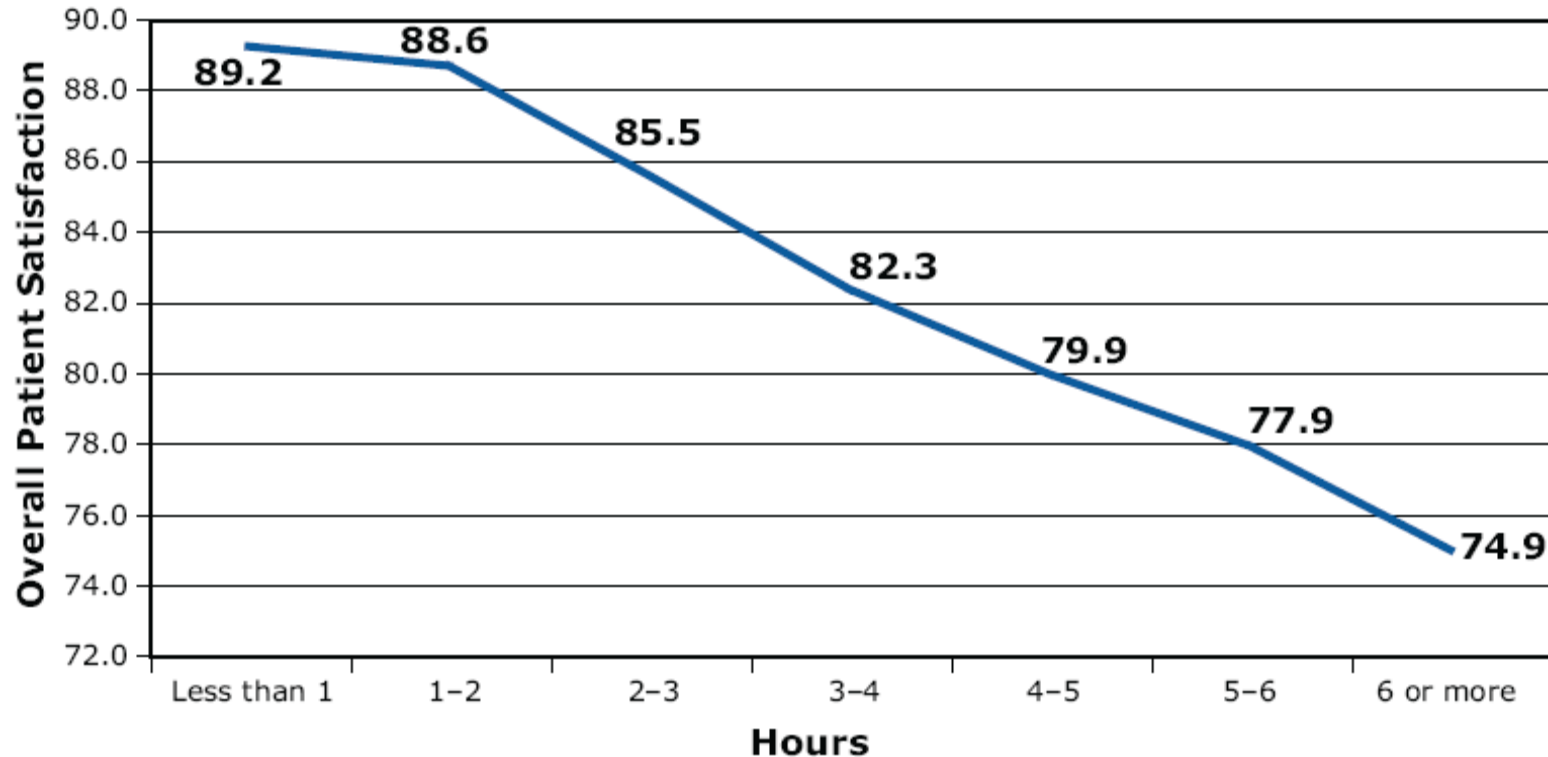Telephone calls, mail, and email
11m
▼ DOWN 1 MIN.

Source: Bureau of Labor Statistics
Photos: Reuters (2), Getty Images (11)

Leisure and sports (excluding TV watching)
2h 9m ▲ UP 1 MIN.

Waiting and the Emergency Department

Patient Satisfaction by Time Spent in ED

Represents the experiences of 1,524,726 patients treated at 1,656 EDs nationwide between January 1 and December 31, 2007

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Satisfaction

Timeliness of care has a strong correlation to patient satisfaction (1,2) with wait time to be treated by a physician having the most powerful association with satisfaction. (3)

1. Bursch B, Beezy J, Shaw R. Emergency department satisfaction: what matters most?
   Ann Emerg Med. 1993;22:586-591.

2. Thompson DA, Yarnold PR, Williams DR, et al. Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality on patient satisfaction in the emergency department .
   Ann Emerg Med. 1996;28:657-665.

3. Boudreaux ED, D'Autremont S, Wood K, et al. Predictors of emergency department patient satisfaction: stability over 17months.
   Acad Emerg Med. 2004;11:51-58.

As Hospital's ED Percentile Ranking Increases, So Does Its HCAHPS "Overall" Percentile Ranking

Relationship: ED and HCAHPS "Overall" Percentile Rankings
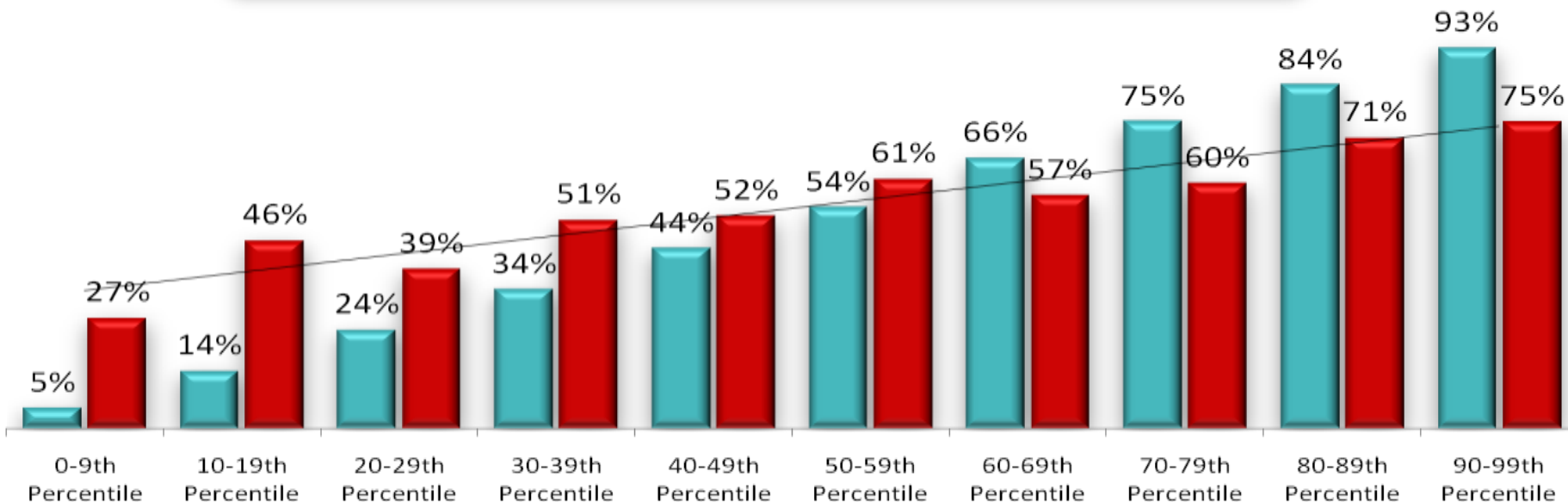
Legend:
- Emergency Department Percentile Rank
- HCAHPS "Overall" Percentile Rank
- Linear (HCAHPS "Overall" Percentile Rank)

Percentile	ED Percentile Rank	HCAHPS "Overall" Percentile Rank
0-9th Percentile	5%	27%
10-19th Percentile	14%	46%
20-29th Percentile	24%	39%
30-39th Percentile	34%	51%
40-49th Percentile	44%	52%
50-59th Percentile	54%	61%
60-69th Percentile	66%	57%
70-79th Percentile	75%	60%
80-89th Percentile	84%	71%
90-99th Percentile	93%	75%

Expectations: Voice of the Customer

2009 National Emergency Department Priority Index

Survey items are correlated to Overall Satisfaction

Represents the experience of 1,501,672 patients treated at 1,893 Emergency Departments nationwide between January 1 and December 31, 2009.

Survey Item	n	Mean	Correlation	Rank
F2. Degree to which staff cared about you as a person	1,412,794	82.0	0.888	1
F4. Likelihood of your recommending our emegency department to others	1,434,598	82.0	0.877	1
F1. How well were you kept informed about delays	1,296,405	71.3	0.808	3
F68. Overall rating of care received during your visit	1,455,413	83.0	0.909	3
F41. How well was your pain controlled	1,233,566	77.9	0.803	5
B4. Nurses' concern to keep you informed about your treatment	1,455,801	83.1	0.828	6
E2. Staff concern to keep family or friends informed about your status during your course of treatment	1,051,479	83.7	0.844	7
C1. Waiting time in the treatment area before you were seen by a doctor	1,441,795	74.4	0.749	8
B3. Nurses' attention to your needs	1,462,256	85.3	0.823	9
C5. Doctor's concern to keep you informed about your treatment	1,440,863	83.1	0.796	9
C4. Doctor's concern for your comfort while treating you	1,432,143	83.5	0.802	9
E1. Courtesy with which family or friends were treated	1,089,291	86.5	0.840	12
C7. Information you were given about caring for yourself at home (e.g., taking medications, getting follow up care)	1,372,367	83.6	0.787	13
B76. Degree to which the nurses took time to listen to you	1,465,999	86.4	0.812	14
A4. Waiting time before you were brought to the treatment area	1,424,740	77.9	0.681	15
C75. Degree to which the doctor took time to listen to you	1,446,723	84.9	0.782	15
A5. Comfort of the waiting area	1,390,180	78.1	0.678	17
B5. Nurses' concern for your privacy	1,440,212	86.3	0.778	18
D3. Waiting time for radiology test	878,462	82.1	0.657	19
A87. Helpfulness of the person who first asked you about your condition	1,460,969	86.2	0.708	20
C2. Courtesy of the doctor	1,457,976	87.1	0.771	21
B1. Courtesy of the nurses	1,478,693	88.4	0.784	22
D52. Concern shown for your comfort when your blood was drawn	756,554	87.0	0.694	23
A2. Privacy you felt when you were asked about personal/insurance information	1,380,497	86.6	0.694	23
A3. Ease of giving your personal/insurance information	1,377,180	87.5	0.699	23
E3. Staff concern to let a family member or friend be with you while you were being treated	1,068,175	88.2	0.765	26
D2. Courtesy of the person who took your blood	772,869	87.9	0.698	27
A28. Courtesy of the person who took your personal/insurance information	1,395,950	87.6	0.688	28
A86. Waiting time before staff noticed your arrival	1,470,178	87.5	0.641	29
D65. Concern shown for your comfort during your test	882,293	88.9	0.650	30
D4. Courtesy of the radiology staff	877,408	89.6	0.641	31

Inpatient Priority Index

Survey items are correlated to Overall Mean Score

Based on responses of 3,047,705 patients from 2,162 hospitals received between January 1, 2009 and December 31, 2009

Survey Item	Mean	Correlation	Priority Rank
Response to concerns/complaints made during your stay	84.0	0.804	1
Staff effort to include you in decisions about your treatment	84.4	0.798	2
Degree to which hospital staff addressed your emotional needs	84.4	0.798	3
Waiting time for tests or treatments	80.9	0.682	4
How well the nurses kept you informed	85.9	0.773	5
Explanations about what would happen during tests and treatments	85.1	0.735	6
Accommodations and comfort for visitors	83.4	0.673	7
Promptness in responding to the call button	84.6	0.692	8
Amount of attention paid to your special or personal needs	86.9	0.760	8
Time physician spent with you	81.9	0.667	8
Staff concern for your privacy	86.9	0.756	8
How well staff worked together to care for you	88.9	0.817	12
Likelihood of your recommending this hospital to others	88.3	0.783	12
Pleasantness of room decor	79.7	0.620	14
Instructions given about how to care for yourself at home	85.9	0.704	15
How well physician kept you informed	84.8	0.679	16
Overall rating of care given at hospital	89.2	0.813	16
Temperature of the food (cold foods cold, hot foods hot)	78.7	0.579	18
Physician's concern for your questions and worries	85.9	0.683	18
Speed of discharge process after you were told you could go home	80.5	0.607	18
Room cleanliness	83.8	0.629	21
How well your pain was controlled	86.2	0.697	21
Noise level in and around room	76.3	0.545	23
Quality of the food	75.3	0.538	23
Staff attitude toward your visitors	88.5	0.748	23
Room temperature	79.2	0.547	26
Nurses' attitude toward your requests	88.7	0.747	27
Speed of admission process	83.5	0.573	28
Extent to which you felt ready to be discharged	85.5	0.629	29
Skill of the nurses	90.5	0.734	30
Courtesy of the person who took your blood	88.4	0.676	30
Friendliness/courtesy of the nurses	91.5	0.715	32
Courtesy of the person who started the IV	88.9	0.671	33
Courtesy of the person who cleaned your room	87.1	0.599	34
Friendliness/courtesy of physician	89.2	0.658	35
Courtesy of the person who served your food	87.4	0.599	36
Skill of physician	91.5	0.632	37
Courtesy of the person who admitted you	89.9	0.610	38

Skill of the physician #37/38 on Inpatient Priority Index

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Financial Impact P4P + HCAHPS– An Example

Hospital Profile:

- 276-bed hospital
- 22 bed ED
- Patient Revenue: $630 million
- Payor mix: 45% Medicare

Impact:

- *1% impact (current P4P projection for 2013) = $2,835,000*
- *30%* attributed to HCAHPS performance = $850,500 potential risk*
- *70%* attributed to Core Measure performance = $1,984,500 potential risk*

*Impact percents are estimates based on the latest forecasts (11.2.10).

Managing Waits

▼ Some organizations "manage the waits" at their facilities quite deftly

Best-in-Class:

– Disney (the entertainment experience/economy)

– Ritz-Carlton (Hotels)

– Casinos (think Las Vegas)

– Starbucks (retail and the service experience/economy)…

Managing Waits

- The classic analysis
  - <u>The Psychology of Waiting Lines</u> by David Maister (1985).

- An updating and revision
  - <u>Eight Design Principles for Waiting Lines-</u>(*The Psychology of Waiting Lines)* by Donald A. Norman, (2008)

Not all Waits Are Bad

- ▼ Fine Dining
- ▼ Marriage
  - ▼ Note-In my home state-North Carolina-First Cousins MAY marry, but DOUBLE first cousins may not…
- ▼ Buying a handgun
  - ▼ A one week wait in NC
  - ▼ Licensed to carry…

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Some waits are longer than others…

Waiting for
the Perfect Man
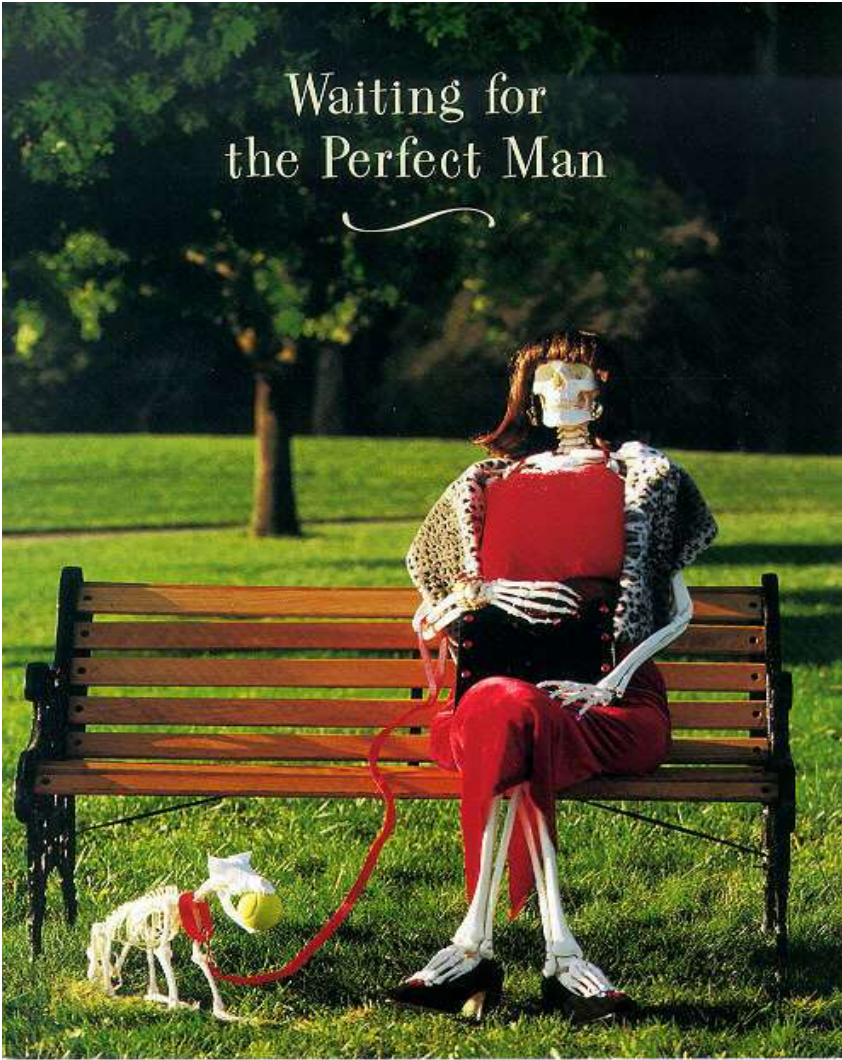
"Products are consumed, services are experienced"
Steven Levitt

Service

- It isn't just LOS or TAT or time intervals that matter, it's the <u>perception</u> of flow and service that matters

- Onstage-Offstage

- Expectation Creation

- Flow and Waits and Service are inextricably linked

- Managing waits and deploying service skills can make a difference

It's not about being perfect… service recovery and customer loyalty

Recovery Paradoxon

Customer Loyalty

Customer with service failure and successful recovery

Customers without service failure

Service Failure

Service Recovery
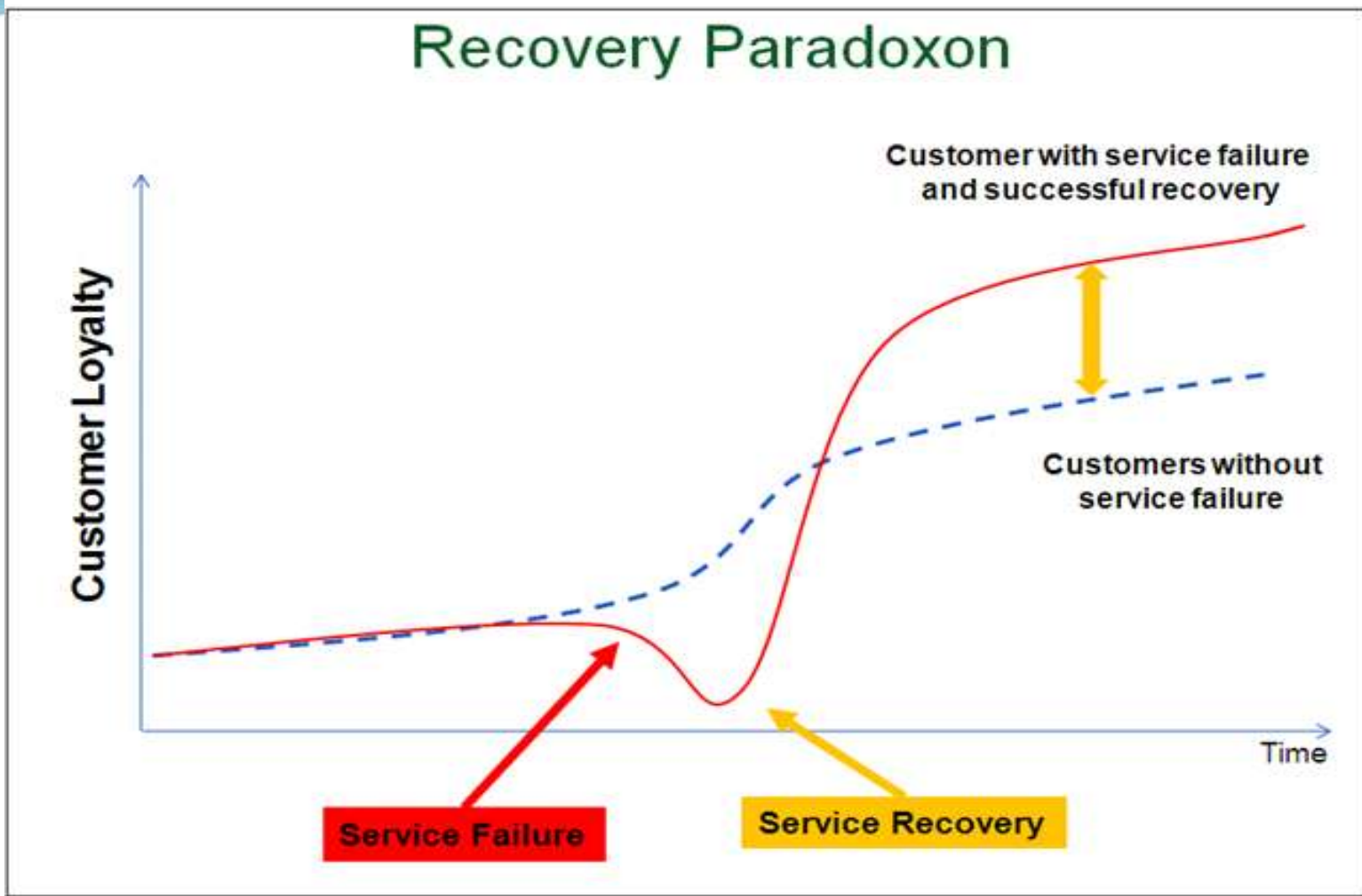
Time

We know there are choices and trade-offs to be made…

Fast
Cheap
Good

Pick any two.

Emergency ←

Managing Waits
and
the Psychology of Waiting…

Unoccupied time feels longer

than occupied time…

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Unoccupied time feels longer than occupied time

Disney is a master of this principle:

▼ Disney entertains you while you are in line with tactics like strategically-placed videos or characters in costume.

    ▼ Disney has "pre-show" entertainment.

Unoccupied time feels longer than occupied time

Emergency Department applications:

- ▼ Televisions in the waiting room.

- ▼ Provide current magazines and relevant health information for patients to read.

- ▼ Make room for people and company, such as friends & family

- ▼ Have patients fill out healthcare and registration forms to fill up the time.

How far can we go…characters in costume…infotainment…diversions…

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Pre-process waits feel longer

than in-process waits…

Pre-process waits feel longer than in-process waits

People want to get started…

Initiating any method of service-related activity or deploying time fillers gives the impression that the process has already begun.

Restaurants train their wait staff to acknowledge customers as soon as they are seated with a greeting such as "I'll be right with you". They provide menus and offer drinks right away. They often visit the table again to mention the "specials". All of these small interactions move the process along.

Pre-process waits feel longer than in-process waits

A well-run doctor's office or Emergency Department will move patients along sequentially; there is no need to keep the patient waiting until everything is ready.

Have a triage nurse meet the patient, gather information and move them into a room. If patients feel they are moving through the system, the wait seems more tolerable.

Maintaining Forward Flow

This…   And not this…

Anxiety makes waits seem longer

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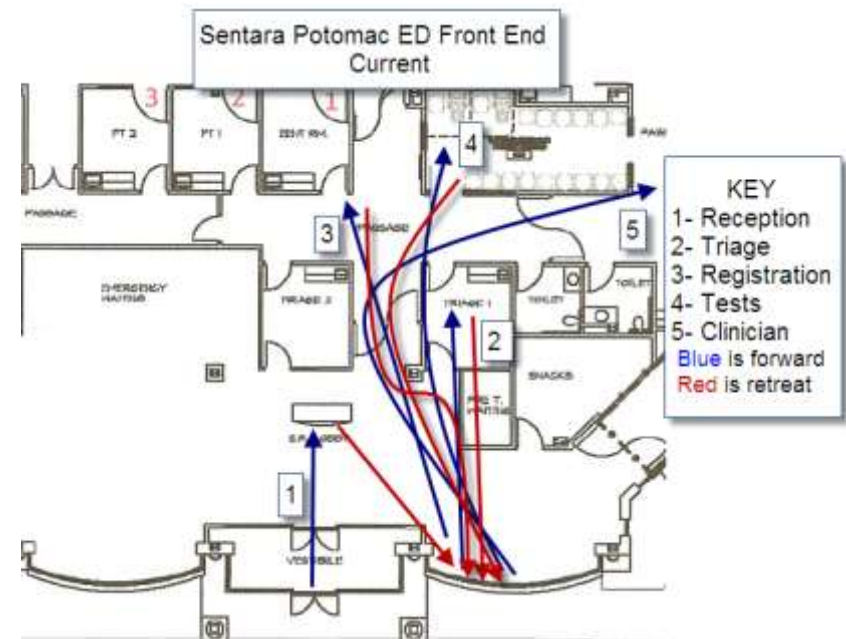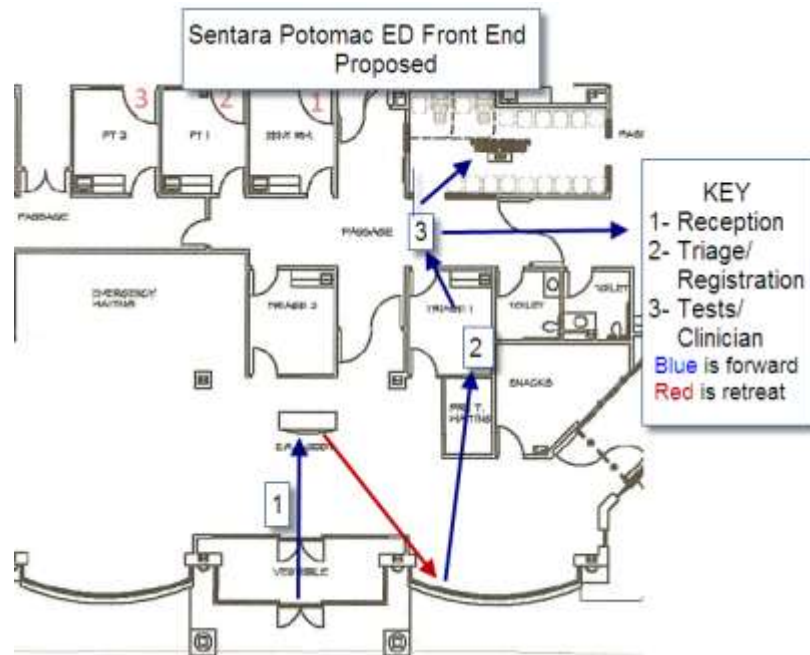
Anxiety makes waits seem longer

Patients are often anxious.

(By definition they are probably having a bad day already…)

Simply letting patents and their significant others know what the waits are, why they are having to wait, and what to expect can alleviate family and patient anxiety.

▼ Surveys of ED patients suggest that patients would like to be contacted while they wait in the ED every 20 to 30 minutes.

▼ Surveys of the ED staff will suggest that ED healthcare workers think that contacting or "touching" patients once an hour is plenty.

Establish a deliberate policy of regular contact, and your patient satisfaction will climb…

Patients involved with seated interactions with physician overestimated time spent with provider…

Provider posture (seated vs. standing) influences patients estimates of time spent at bedside:

▼ Mean length of encounter was 8.6 minutes

▼ Patients involved in seated interactions overestimated time providers spent by an average of 1.3 minutes

▼ Patients involved in standing interactions underestimated time spent by an average of 0.6 minutes

Source: Ann Emerg Med. 2008 Feb;51(2):188-93, 193.e1-2. Epub 2007 Jun 27. To sit or not to sit? Johnson RL et al

Uncertain waits are longer than known, finite waits

Uncertain waits are longer than known, finite waits…

Dominos

Uncertain waits are longer than known, finite waits

When a patient or family member asks a "How long?" question, it's not just about time…

…If a patient asks how long it will take to get the results of a CT scan, give a finite amount of time. ..

Saying "soon" or "it's a busy day" creates the impression of a longer and uncertain wait. Even better, give a finite amount of time that is actually a bit longer than the scan will likely take. This will lead to a more satisfied patient because you will be exceeding the expectations that you have just set.

Disney is a master at this-Disney tells you the wait is going to be 45 minutes when they know it will be 30.

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Physician communication is highly correlated with better patient adherence…

▼ There is a ***19% higher risk of non-adherence*** among patients whose physician communicates poorly than among patients whose physician communicates well.

▼ With physician training, the odds of ***patient adherence are 1.62 times higher*** than when a physician receives no training.

Source: Med Care. 2009 Aug;47(8):826-34. Physician communication and patient adherence to treatment: a meta-analysis. Zolnierek, KB et al

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Unexplained waits are longer than explained waits

Unexplained waits are longer than explained waits

In the Emergency Department, keep your patients informed.

- ▼ If they know that a "code" or a major trauma has come in, they often (though not always…) understand why they have to wait.
- ▼ The practice (or habit…) of rounding…

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THE EFFECTS OF EMERGENCY DEPARTMENT STAFF ROUNDING ON PATIENT SAFETY AND SATISFACTION

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Reprint Address: Christine M. Meade, PHD, 105 Pelham Inlet, Waynesboro, VA 22980

☐ Abstract—Background: Two recent inpatient studies documented that regular nursing staff rounding increased patient safety and satisfaction. However, the effect of systematic emergency department (ED) staff rounding on patient safety and satisfaction has not been adequately tested. Study Objective: The objective of this study was to test the effectiveness of three different rounding techniques. Methods: An 8-week study using a quasi-experimental, non-equivalent group, time-sampling design was conducted in 28 EDs. The three rounding protocols were: 1) rounds every 30 min; 2) rounds every hour; 3) rounds every hour with an Individualized Patient Care tactic (IPC; patients were asked to name their most important expectation for the ED visit). Baseline data were collected the first 4 weeks; rounding was done the second 4 weeks. Outcome measures compared the baseline to the rounding period data for patients who left without being seen (LWBS), those leaving against medical advice (AMA), patient satisfaction, call light use, and nursing station encounters. Results: The three rounding protocols combined reduced LWBS by 23.4%, leaving AMA by 22.6%, falls by 58.8%, call light use by 34.7%, and approaches to the nursing station by 39.5%. Patient satisfaction ratings for overall care and pain management increased significantly. The protocol using the IPC tactic produced the most significantly improved outcomes. Conclusions: Rounding in the ED reception and treatment areas is effective and improves outcomes. Further research should determine the optimal design for rounding considering the mixed shifts in EDs, seek ways to increase communicating delays to patients, and investigate how to integrate rounding with physician activities. © 2008 Elsevier Inc.

☐ Keywords—Patient safety; left without being seen; leaving against medical advice; patient satisfaction; ED staff interruptions

INTRODUCTION

Emergency departments (EDs) generate 42% of all hospital admissions nationally (1,2). Besides being an important revenue source for the inpatient side, patients' experiences in an ED affect them personally, can influence future hospital choice, and generate either positive or negative word-of-mouth to friends. Unfortunately, satisfaction ratings [...] other hospital dep[...] veal that inpatients [...] satisfaction rating [...] ences when compa[...] normal admissions [...] riences are long-lasting, it is important to improve patients' experiences in the ED to ensure optimal patient [...]

Rounding treats:
- Anxiety
- Uncertain waits
- Unexplained waits

Christine M. Meade, PHD,* Julie Kennedy, RN, BSN, TNS,† and Jay Kaplan, MD, FACEP‡ JEM 2008

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Rounding in the ED reception and treatment areas is effective and improves outcomes

Using 3 rounding protocols* combined <u>reduced</u>:

  ▼ 22.6% leaving against medical advice

  ▼ 23.4% left without being seen

  ▼ 34.7% call light use

  ▼ 39.5% approaches to nurses station

  ▼ 58.8% falls

Patient satisfaction ratings for overall care & pain management ***increased significantly***.

*1) Rounds every 30 minutes
 2) Rounds every hour
 3) Rounds every hour with Individualized Patient Care

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Individualized Patient Care Added to Hourly Rounding

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Individualized Patient Care

"What is one thing I can do for you (or your child) to make sure you get very good/excellent care today?"

_____

_____   Priority Index/
                                      Key Drivers:
_____
                                      _____
_____
                                      _____

                                      _____

Note: This card was completed at triage or when patient was roomed.
Placed with the chart or IPC documented on white board.

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Providing Information to ED Patients Every 15 minutes improves patients' perceived length of stay, efficiency and clinical skills of Emergency Physician

Providing personal interaction and clinical information in 15-minute intervals to ED patients produced the following results:
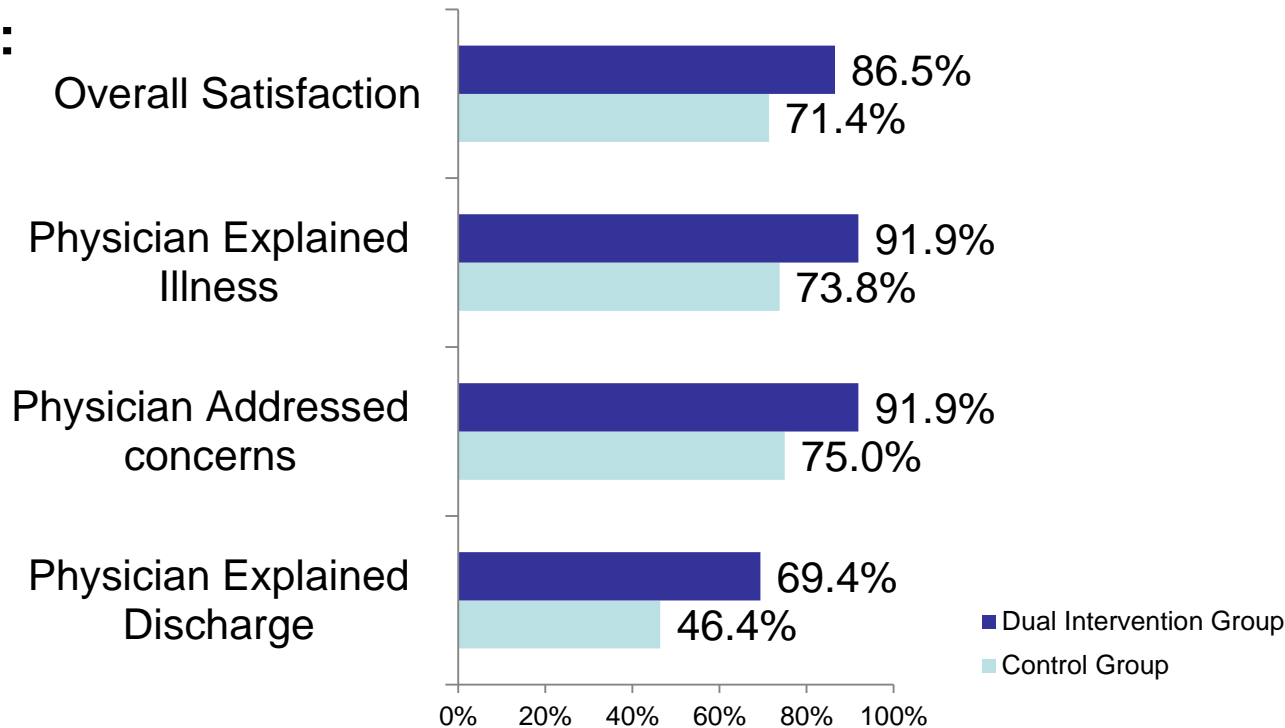
▼ **Perceived length of stay was shorter** (92.6 minutes vs. 105.5 minutes in control group)

▼ **Proportion of ED patients rating Emergency Staff Physician as "excellent" or "very good" was significantly higher** in the intervention group

Source: Am J Emerg Med. 2002 Oct;20(6):506-9. Provision of clinically based information improves patients' perceived length of stay and satisfaction with EP. Tran TP et al

Providing Information to ED Patients Increases Satisfaction

Dual Intervention: Standardized use of **dry erase board** to identify patient's illness, treatment and follow up care *AND* **brochure** outlining process of visiting ED and explaining reasons for waits and delays

Results:

Category	Dual Intervention Group	Control Group
Overall Satisfaction	86.5%	71.4%
Physician Explained Illness	91.9%	73.8%
Physician Addressed concerns	91.9%	75.0%
Physician Explained Discharge	69.4%	46.4%

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Providing Information to ED Patients Increases Willingness to Return to ED

Dual Intervention: Standardized use of **dry erase board** to identify patient's illness, treatment and follow up care *AND* **brochure** outlining process of visiting ED and explaining reasons for waits and delays

Results:

Willingness to return to ED if needed

94.4%

82.1%

■ Dual Intervention Group
■ Control Group

0% 20% 40% 60% 80% 100%
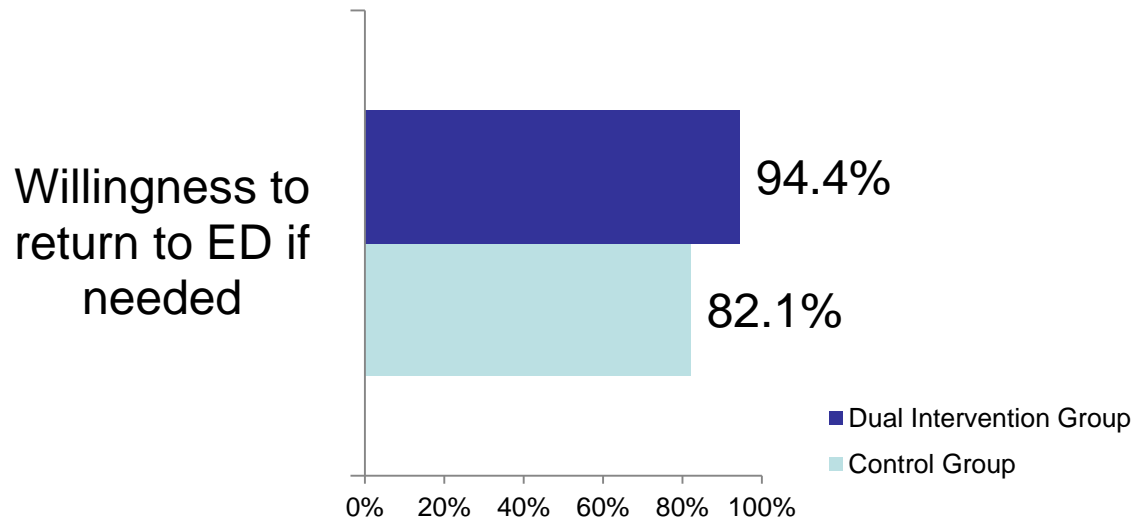
Source: Annals of Emergency Medicine, Vol. 46, No. 3: September 2005 – Research Forum Abstract #427
The Effect of Information Delivery on Patient Satisfaction in the Emergency Department White P et al

Patients who receive ED information rated their overall satisfaction higher and other measures too

Information distributed to ED patients upon arrival described ED function and patient evaluation time.

Results:

▼ Patients who received ED information rated their overall satisfaction higher than did the control group.

▼ Other items rated significantly higher include:

   ▼ Physician skill and competence

   ▼ Physician concern and caring

   ▼ Whether the patient would use the same ED again

Source: Ann Emerg Med. 1993 Mar;22(3):568-72. Effect of emergency department information on patient satisfaction. Krishel S et a

Unfair waits are longer than equitable waits

Unfair waits are longer than equitable waits

It can be easy for patients in the ED to feel like they are being given a "lesser" priority…

If you have Fast Track waiting room in the ED designed to handle the more acute and straightforward cases, and it is located in the same area as the main waiting room, patients who are not as acute and straightforward are likely to feel dissatisfied. They will notice they aren't moving through as fast as the other patients and they don't know why.

It is important to set up your rules (your operational guidelines) to match your patient's sense of equity.

The more valuable the service, the longer the customer will wait

HEALTHGRADES

The First Annual
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American Hospitals Study

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HealthGrades Evaluates Hospital Emergency Medicine for the First time

Study of Patients Admitted through Emergency Departments Finds Wide Range of Mortality Rates

Hospitals in Top 5% Identified on www.healthgrades.com

GOLDEN, Colo. (June 23, 2010) – The quality of emergency medical care at the nation's hospitals varies widely – both individually and by state -- according to a new HealthGrades study released today that, for the first time, examines mortality rates for patients entering hospitals through emergency departments.

The first annual *HealthGrades Emergency Medicine in American Hospitals Study* examined more than 5 million Medicare records of patients admitted through the emergency department of 4,907 hospitals from 2006 to 2008 and identified hospitals that performed in the top 5% in the nation in emergency medicine.

Comparing the group of hospitals in the top 5% with all others, the study found that the group had a 39% lower risk-adjusted mortality rate. These top-performing hospitals improved their outcomes over the years 2006 through 2008 at a faster rate than all other hospitals, 16% compared with 10%.

The first-annual analysis is based on risk-adjusted mortality outcomes for patients admitted through the emergency department for eleven of the most common life-threatening diagnoses in the Medicare population. If all hospitals performed at the level of the top 5%, 118,014 individuals could have potentially survived their emergency hospitalization.

Hospitals in the top 5% were identified this morning on www.healthgrades.com as recipients of the HealthGrades 2010 Emergency Medicine Excellence Award – 255 in total.

Annually, 119 million individuals visit an emergency department, but the number of emergency rooms themselves has been decreasing, leading to overcrowding and significant challenges for the hospitals that operate them, according to the CDC.

"Half of hospital admissions now begin with hospital emergency departments, up from 36% in 1996," said Rick May MD, a vice president with HealthGrades and co-author of the study, quoting a recent CDC report. "With more individuals expected to visit emergency departments, this HealthGrades study should prove to be a valuable resource for both hospitals and patients in that it identifies hospitals that are the nation's quality leaders in emergency medical care."

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The more valuable the service, the longer the customer will wait

The more valuable the perception of service, the longer patients will be willing to wait…

If your facility is considered a top-notch Emergency Department, surgical center or hospital, patients will tolerate longer periods of waiting.

If you are perceived as the "band-aid station" people will not be as tolerant of waiting.

One way of managing waits is to build your brand and your reputation.

-Make your facility the place where people and patients want to go.

-Your patients will be much more accepting of waits and delays.

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Solo waits feel longer than group waits

Solo waits feel longer than group waits

How can you leverage this phenomenon, or this principle in your Emergency Department…

The Psychology of Waiting
David Maister (1985)

▼ Unoccupied time feels longer than occupied time

▼ Pre-process waits feel longer than in-process waits

▼ Anxiety makes waits seem longer

▼ Uncertain waits are longer than known, finite waits

▼ Unexplained waits are longer than explained waits

▼ Unfair waits are longer than equitable waits

▼ The more valuable the service, the longer the customer will wait

▼ Solo waits feel longer than group waits

The Psychology of Waiting
Donald A. Norman, (2008)

Eight Design Principles for Waiting Lines- (*The Psychology of Waiting Lines*)

1. Emotions Dominate

2. Eliminate Confusion: Provide a Conceptual Model, Feedback and
   Explanation

3. The Wait Must Be Appropriate

4. Set Expectations, Then Meet or Exceed Them

5. Keep People Occupied: Filled Time Passes More Quickly Than Unfilled
   Time

6. Be Fair

7. End Strong, Start Strong

8. The Memory of an Event Is More Important Than the Experience

DONALD A. NORMAN--*The Psychology of Waiting Lines*

The Psychology of Waiting:
David Maister's Eight Principles and their ED Service Equivalents

- **Unoccupied time feels longer than occupied time**
  - TVs, magazines, health care material
  - Company-Friends and family
  - ROS forms, kiosks, 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
  - 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
  - Address the obvious—pre-thought out and sincerely deployed scripts
  - 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

The Psychology of Waiting
In the Emergency Department

8 Principles for Managing ED Wait Times

Researchers are bringing classic insights to the realm of subjective experience. *The Psychology of Waiting Lines* by David Maister illustrates compelling anecdotes, data and understanding about the psychology of waiting. Frustration and anxiety increase when specific waiting conditions exist, and service encounters that begin with unmet expectations can set the tone for a negative experience overall.

Emergency departments can significantly lessen frustration and anxiety for patients by modifying their environment, process and procedures using eight basic principles.

1 Unoccupied Time Feels Longer Than Occupied Time
- Have televisions, current magazines and relevant health information.
- Make room for friends and family.
- Have patients fill out healthcare and registration forms while they are waiting.

2 Pre-Process Waits Feel Longer Than In-Process Waits
- When patients feel they are moving through the system, waits seem more tolerable.
- Move patients along sequentially; there is no need to keep the patient waiting until everything is ready.
- Have a triage nurse meet the patient, gather information and move them into a room.

3 Anxiety Makes Waits Seem Longer
- Let patients know why they are waiting and what to expect to alleviate anxiety.
- Surveys show ED patients prefer being contacted every 20 to 30 minutes while waiting.
- A deliberate policy of regular and consistent contact with patients will significantly increase patient satisfaction.

4 Uncertain Waits Are Longer Than Known, Finite Waits
- If a patient asks how long a specific process will take, give a finite amount of time.
- Responding with "soon" or "it's a busy day" creates the impression of a longer wait.
- Estimating a slightly longer time than the process will likely take will lead to a more satisfied patient.

5 Unexplained Waits Are Longer Than Explained Waits
- If the patients know that a major trauma or critical emergency came in, they are often more understanding about having to wait.
- Rounding on the ED reception and treatment areas decreases patient anxiety and improves patient satisfaction and patient safety.

6 Unfair Waits Are Longer Than Equitable Waits
- Patients are likely to feel dissatisfied if they feel they are unfairly being made to wait longer than others.
- If you have a Fast Track in the ED, try to have a separate waiting room for those patients.
- Set up operational patient-flow guidelines to match your patient's sense of equity.

7 The More Valuable the Service, the Longer the Customer Will Wait
- Patients will tolerate longer periods of waiting if your healthcare facility is considered a great ED, surgical center or hospital.
- Patients will not want to wait long at what is considered a "band-aid station."
- Building your brand through performance, service and reputation positively impacts how long patients are content to wait for treatment.

8 Solo Waits Feel Longer Than Group Waits
- Solo waits feel isolated and prolonged.
- Encourage the involvement (or presence) of family members, friends and significant others.
- Make sure to regularly round on and check in with patients who are waiting in your ED.

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Putting these principles to work

A cardiologist, a friend of mine, <u>read this article </u>(David Maister- *The Psychology of Waiting Lines*), and this article alone, and went back home and made changes to his office practice...

He changed ***nothing*** else about the practice except how his staff managed the various waits.

<u>He did not redesign his office, hire more staff or change the hours</u>.

He simply applied the principles outlined here.

His <u>patient satisfaction</u> benchmarking scores improved <u>from worst</u> in his area <u>to first</u>-solely because he managed the waits for his patients.

The Psychology of Waiting Lines

By David H. Maister

Introduction

In one of a series of memorable advertisements for which it has become justly famous, Federal Express (the overnight package delivery service) noted that: "Waiting is frustrating, demoralizing, agonizing, aggravating, annoying, time consuming and incredibly expensive." (1)

The truth of this assertion cannot be denied: there can be few consumers of services in a modern society who have not felt, at one time or another, each of the emotions identified by Federal Express' copywriters. What is more, each of us who can recall such experiences can also attest to the fact that the waiting-line experience in a service facility significantly affects our overall perceptions of the quality of service provided.

Once we are being served, our transaction with the service organization may be efficient, courteous and complete: but the bitter taste of how long it took to get attention pollutes the overall judgments that we make about the quality of service.

various 'queue management' techniques: for example, what the effects are upon average waiting times of adding servers, altering 'queue discipline' (the order in which customers are served), speeding up serving times, and so on. What has been relatively neglected, however, is much substantive discussion of the experience of waiting.

As Levitt reminds us, "Products are consumed, services are experienced." Accordingly, if managers are to concern themselves with how long their customers or clients wait in line for service (as, indeed, they should), then they must pay attention not only to the readily-measurable, objective, reality of waiting times, but also how those waits are experienced. It is a common experience that a two minute wait can feel like nothing at all, or can feel like 'forever'. We must learn to influence how the customer feels about a given length of waiting time.

In this paper, I shall discuss the psychology of waiting lines, examining how waits are experienced and shall attempt to offer specific managerial

Pain is inevitable, suffering is optional…

Dalai Lama

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THE EFFECTS OF EMERGENCY DEPARTMENT STAFF ROUNDING ON PATIENT SAFETY AND SATISFACTION

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□ Abstract—Background: Two recent inpatient studies documented that regular nursing staff rounding increased patient safety and satisfaction. However, the effect of systematic emergency department (ED) staff rounding on patient safety and satisfaction has not been adequately tested. Study Objective: The objective of this study was to test the effectiveness of three different rounding techniques. Methods: An 8-week study using a quasi-experimental, non-equivalent group, time-sampling design was conducted in 28 EDs. The three rounding protocols were: 1) rounds every 30 min; 2) rounds every hour; 3) rounds every hour with an Individualized Patient Care tactic (IPC; patients were asked to name their most important expectation for the ED visit). Baseline data were collected the first 4 weeks; rounding was done the second 4 weeks. Outcome measures compared the baseline to the rounding period data for patients who left without being seen (LWBS), those leaving against medical advice (AMA), patient satisfaction, call light use, and nursing station encounters. Results: The three rounding protocols combined reduced LWBS by 23.4%, leaving AMA by 22.6%, falls by 58.8%, call light use by 34.7%, and approaches to the nursing station by 39.5%. Patient satisfaction ratings for overall care and pain management increased significantly. The protocol using the IPC tactic produced the most significantly improved outcomes. Conclusions: Rounding in the ED reception and treatment areas is effective and improves outcomes. Further research should determine the optimal design for rounding considering the mixed shifts in EDs, seek ways to increase communicating delays to patients, and investigate how to integrate rounding with physician activities. © 2008 Elsevier Inc.

□ Keywords—Patient safety; left without being seen; leaving against medical advice; patient satisfaction; ED staff interruptions

INTRODUCTION

Emergency departments (EDs) generate 42% of all hospital admissions nationally (1,2). Besides being an important revenue source for the inpatient side, patients' experiences in an ED affect them personally, can influence future hospital choice, and generate either positive or negative word-of-mouth comments among family and friends. Unfortunately, EDs nationally receive the lowest satisfaction ratings from patients when compared to all other hospital departments, and additional analyses reveal that inpatients admitted from EDs give lower overall satisfaction ratings for their inpatient hospital experiences when compared to inpatients admitted through the normal admissions process (3). Because negative experiences are long-lasting, it is important to improve pa-

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Coauthored by Thom Mayer, MD, FACEP, FAAP and Kirk Jensen, MD, MBA, FACEP

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▼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
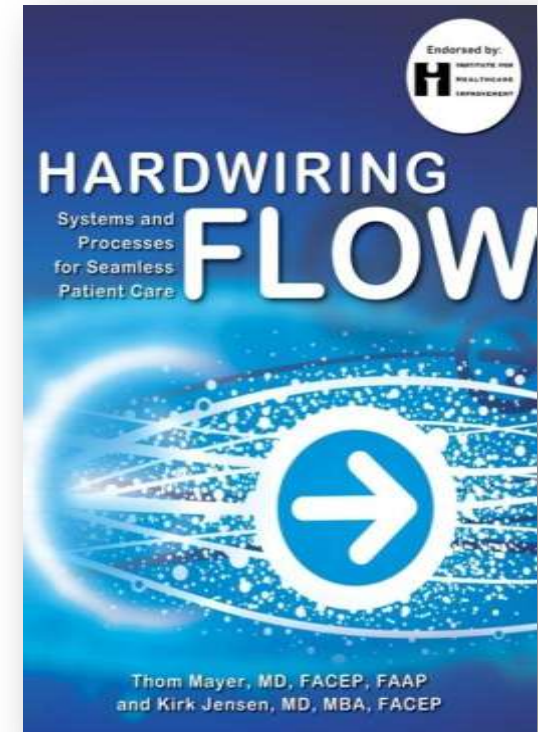
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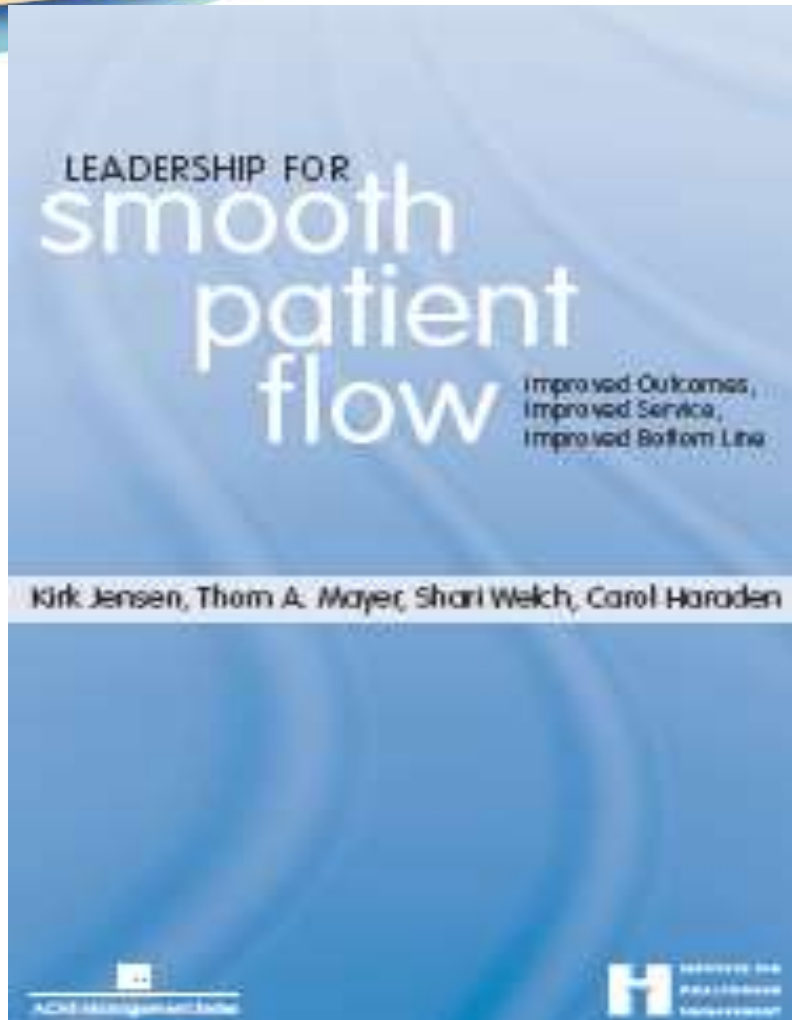
Leadership for Smooth Patient Flow: Improved Outcomes, Improved Service, Improved Bottom Line

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

Publisher--ACHE +Institute for Healthcare Improvement

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)

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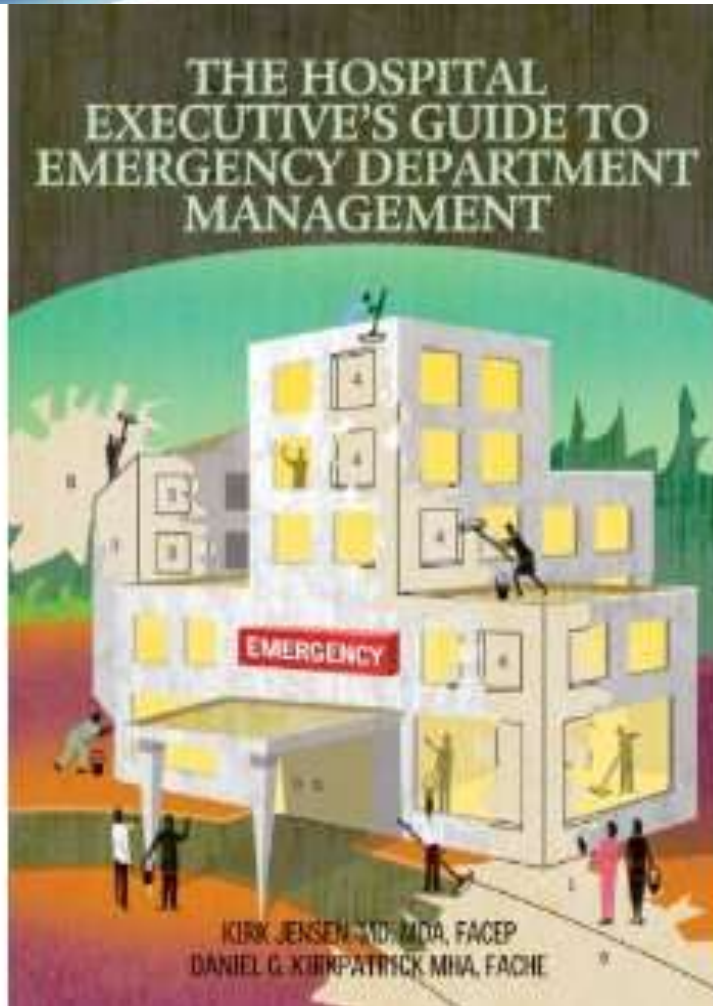
**The Hospital Executive's Guide to Emergency
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