

Operating with efficiency

Sacred Heart gets boost from restructuring

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Jeremy Dillon grimaced: "My boss heard it pop, and I was like, 'Oh, no.'"

The furniture mover for Macy's had dislocated his shoulder and was driven to the emergency room at Sacred Heart Medical Center.

What happened next surprised him. Within minutes he was checked in. A sedative followed and within an hour of his injury, his shoulder was put back into place.

"They just got right to the point," he said. "It might be that I got here on a lucky day."

But luck didn't have anything to do with it, according to John Reamer, emergency room director.

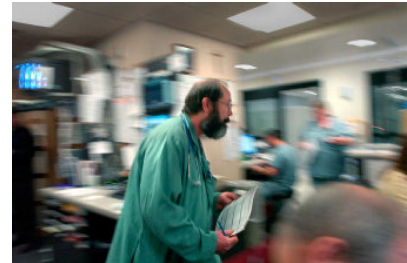
His department has gone through a broad and sometimes painful restructuring that began two years ago and has since spread to the upper floors of the hospital.

The result, he said, is a nimble, efficient emergency room that treats more patients, more quickly. And, Reamer is quick to add, it means that patients receive better care and are more satisfied with their visit.

The restructuring is one reason Spokane's largest private employer has put a stop to unusual financial losses.

In recent years, hospital executives warned that the business end of Spokane's medical industry was in trouble. They pointed to lagging reimbursement rates for Medicare and Medicaid patients. They locked into a high-profile standoff with dominant health insurer Premera Blue Cross. They bargained hard with labor unions.

And perhaps just as importantly, they turned inward, hiring consultants to review how they did business and suggest changes.



Sacred Heart Emergency Department Charge Nurse Kevin Newman is in constant motion as he works the ebb and flow of patients coming to and leaving the hospital. (Photos by Christopher Anderson/The Spokesman-Review)

In the meantime, by the end of 2004, Spokane hospitals were digesting losses. Even Sacred Heart lost money, the first time in recent memory that the hospital was unable to pinch at least a small operating profit.

The city's second-largest hospital, Deaconess Medical Center, had been struggling for years. But a deep \$30 million loss in 2004 led to serious worry about whether the community hospital might be sold or merged. Neither happened and today the hospital's board of directors believes management changes and tough decisions such as closure of pediatric services have put the hospital in the plus column for the foreseeable future.

Though the numbers were less dramatic at Sacred Heart, the change is still impressive, said chief financial officer Michael Banks. End-of-year results have yet to be audited, but Sacred Heart is showing an operating profit of \$15 million in 2005 — an operating margin of 3.5 percent.

But changing a big organization such as Sacred Heart, with 3,100 employees, is never easy.

The hospital hired EMPATH Inc., a San Francisco Bay-area consulting firm, to not just find cost savings, but also find ways to boost revenue. Many frontline managers such as Reamer were initially doubtful that EMPATH, paid \$100,000 a month, could inspire a turnaround.

Today he is a believer.

Consider this: the number of Sacred Heart's emergency room patients went from 47,700 in 2004 to 58,000 in 2005.

Reamer said 2006 will be even busier.

It's especially important in the context that 39 percent of the all hospital admissions originate through the emergency room.

"Emergency departments are the gatekeepers to the hospitals," said EMPATH's Stevan Bosanac.

So the more people an emergency room can help means more patients and more revenue for the entire hospital.

But like everything else in healthcare, nothing is so simple. Money is not necessarily earned by just having more patients.

In fact, emergency rooms are often financial drags on hospital performance. Many uninsured people rely upon emergency rooms for their routine medical needs.

The changes at Sacred Heart don't necessarily change this scenario, Reamer said.

"These folks need help and they're coming anyway," he said. "Part of the reason the (Sisters of Providence) founded this hospital was to take care of the needy."

Instead, the changes are meant to speed up the entire operation. This lessens the time an uninsured patient spends at the hospital and potentially creates room to treat more insured patients.

Retooling the emergency room started with a shock. EMPATH (the name is derived from "emergency medical pathways") initially submitted more than 3,700 suggestions – from minor tinkering to major changes. They ranged from adopting new computer programs to changing staff hours to hanging white marker boards on the wall.

Becky DeMers, a nurse and liaison for the hospital's work with EMPATH, acknowledged the changes were sometimes difficult.

"We won't lie. Things could get really tough around here," she said as Reamer nodded his head in agreement.

Though EMPATH focused on the emergency room, many of the substantial changes were happening in other departments, such as cardiology and neurology.

Each began looking at its staffing numbers and schedules, patient stays and how quickly beds could be turned over.

Hospital managers shy from restaurant comparisons, but turning a bed is akin to turning tables; people won't be served if the room isn't cleaned and set up.

DeMers showed off a computer program that allows departments to view patient numbers and staffing levels. It's meant as a way to share resources. If cardiology, for example, has more people working than needed a particular time of day, a nurse may be asked to help out on a different floor.

The concept is working well enough, DeMers said, that departments with extra staff now check patient numbers and offer to help departments that may be busier at that moment.

The flexibility is a way Sacred Heart can better control its labor costs while at the same time ensure there's room for new patients.

Changes within other departments helped the emergency room overcome two obvious problems, said EMPATH's Bosanac.

First, the waiting room was full. Second, ambulances had to be diverted from Sacred Heart to other area hospitals when the ER was at capacity, which happened an average of 80 hours a month.

"That was just huge," Bosanac said, adding that such problems are not unusual at hospitals across the country.

The packed waiting room and patient backlog led to dissatisfaction and walkouts. In June of 2004, patients had to wait an average of 82 minutes before they could see a doctor. Today the average wait is under a half-hour.

In business terms, the people who chose not to wait for emergency-room care were lost customers. For Sacred Heart, the problem also was evidence that it was shortchanging its mission as a place for healing those in need of medical care.

Today the waiting room is empty. The hospital now calls it that space the reception area. Reamers eyes the empty room as a waste of floor space and admits he would like to see it remodeled and put to better use. He says patients are treated differently, too.

Sometimes it is just small courtesies that count.

Patients are now kept more informed about the status of their visit, Reamers said, and staff is more respectful of privacy, knocking or at least alerting a patient that someone is going to open the door or curtain.

"Obvious things," Reamers said.

"What has happened here is really a transformation that benefits Spokane."

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