Building a Winning Team

A tireless champion for quality and improvement, Dr. Azita Hamedani is leading the University of Wisconsin ED into a new era of health care

By Diana Mahoney

If health care is a team sport, emergency medicine is the Olympics. Training is broad and far-reaching, the hours are long and intense and, on any given day, during any given shift, clinical “success” requires interacting with countless professional colleagues across the spectrum of specialties, often in high-pressure situations, to make rapid-fire decisions based on limited clinical information.

Yet the most difficult part of becoming an emergency physician for Dr. Azita Hamedani, chair of the Department of Emergency Medicine at the University of Wisconsin School of Medicine and Public Health, wasn’t the academic rigor of her Ivy League education (her undergraduate, master’s of public health and medical degrees are from Yale), the physical toll levied by erratic ED shifts, the challenge of rallying teams of specialists or the emotional burden of making life-or-death decisions on the fly. The most difficult part, she admits, was getting support for her choice of specialty.
“When I asked both my mentor and the dean of students at Yale to write my residency match letter for emergency medicine, both initially refused, believing it wouldn’t be the best choice of career,” recalls Dr. Hamedani. Undeterred by their reluctance, she remained determined.

“Emergency medicine had been my passion for a long time,” said Dr. Hamedani. “I had always wanted to be a doctor, but what I most wanted was to be right there on the front line, prepared to respond to a medical emergency anytime, anyplace, anywhere—whether it was a car accident, a stroke, the delivery of a baby. If someone said, ‘Help, I need a doctor,’ I wanted to be able to help.”

Dr. Hamedani spent some time researching the perception and role of emergency medicine and developed a compelling argument supporting the idea that emergency departments (EDs) would play a critical and growing role in the nation’s health care infrastructure. “It was clear to me that, in the direction the health care delivery system was moving, EDs would be the central hub connecting outpatient to inpatient care,” she said, noting that she brought these arguments to her mentors, who ultimately agreed to write her match letter.

Since then, Dr. Hamedani has established herself as a force in emergency medicine. She completed her residency and chief residency in the Harvard Affiliated Emergency Medicine Residency program at Brigham & Women’s Hospital and Massachusetts General Hospital (MGH) in Bos-
ton. Subsequently, she completed a fellowship in hospital administration with a focus on quality management at MGH, under Dr. Peter Slavin, while on faculty as an instructor in the Department of Surgery at Harvard Medical School.

In 2006, Dr. Hamedani relocated to her home state of Wisconsin when she was recruited to be assistant professor in the Division of Emergency Medicine by the University of Wisconsin School of Medicine and Public Health. For the next few years, she served as the associate director and then director of quality for Emergency Medicine.

In 2009, she was named interim division head for Emergency Medicine. At that time, she was tasked with creating an academic emergency medicine program. With her training in frontline emergency care and quality management, she was able to recruit accomplished faculty to the program, increase revenue, manage expenses and introduce multiple initiatives to improve emergency care services. “I had only planned on being in that role for a year—long enough to get things in order to pass our residency site visit. Then I was going back to my quality role,” she said. “Early on, I realized how broken things were, so I started implementing quality programs. I figured I would try to push through as many changes as I could. If they didn’t work, the worst they could do was fire me. I was only committed for the year.”

Not only did the changes work, but the division prospered. At the same time, the patient load “exploded,” with a volume growth of nearly 60% over a handful of years. To support the growth, an $8.7 million expansion was recently approved. The residency program also grew from six positions to 12 per year, and a fourth-year fellowship program was added.

Under Dr. Hamedani’s leadership, the Division of Emergency Medicine became its own department in July 2014, and she was named Chair. In February, the department received a $10 million gift, which will be used for a major expansion. Four million dollars of the gift will be matched by the hospital to double the clinical footprint of the ED, expanding it from 34 beds to more than 50 treatment areas. The balance of the gift will support research, faculty development, education and training as well as the establishment of four new endowed chairs, including a vice-chair for research, which will allow the department to recruit nationally recognized leaders in emergency medicine.

Dr. Hamedani’s success has not gone unnoticed. In 2012, she was selected as the National Outstanding Emergency Department Director of the Year by the American College of Emergency Physicians. In addition, that same year, she received the Early Career Faculty Award from the Academy of Women in Academic Emergency Medicine. This past year, she was recognized locally by Madison Magazine for a peer selected Service to Profession Award.

Understanding that managing the evolving role of emergency medicine in the new health care landscape requires more than passion and commitment, Dr. Hamedani recently completed a two-year MBA program through Northwestern University’s Kellogg School of Management. “Improving the health care delivery system in a dramatic enough way to be meaningful will require new reimbursement models that better align reimbursement with desired process changes. The more business/finance/strategy physicians know, the more they can be meaningfully involved,” she said.

Dr. Hamedani recently talked with Partners about some of the challenges of growing and running an ED in today’s health care culture, and she offered some thoughts on the anticipated ED CAHPS program.

Partners: Has the perception of emergency medicine changed from when you were starting out, struggling to get support for your choice?

Dr. Hamedani: There is still a tension that exists. On the one hand, people treat the ED as the stepchild of “real” medicine. On the flip side, more people are seeking care from EDs than ever before. The volume is continuously going up, and it’s not just among the uninsured. In fact, the utilization rate among the insured is rising faster than among the uninsured. More and more patients—and their primary care doctors—are taking advantage of the ED’s 24/7, one-stop shop for all their ailments. Where it used to be that primary care physicians might see patients with certain acute conditions in their office, more and more they will have them go directly to the ED, especially if they think the patient might require more time or resources than they can provide. In this way, expectations are changing. EDs have become a portal for patients to get care very quickly. And for patients, they feel like, ‘Okay, I’m here. Do everything.’ As these care expectations have increased, so has patient volume, but resources haven’t quite caught up yet.

Partners: How do you think the anticipated ED CAHPS surveying will affect emergency care?

Dr. Hamedani: Ideally it will lead to improvements in the patient experience, but there will be challenges. For example, one of the ways the patient experience has improved in the outpatient setting is that primary care providers are very efficient about seeing patients on time and
Q&A

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caring for their routine needs. Patients who may require more resources or have acute needs are sometimes sent directly to the ED, including patients with chronic pain and chronic disease. These patients usually require a lot of time and attention, yet there is often less that we can do for them in the ED setting. There are usually psychosocial components to consider in their management. These and other patients who fall into the category of high utilizers—those with substance abuse or depression, for example—may be less likely to rate their experience positively, because they’re not getting the relief or answers they were looking for. Unfortunately, the more challenging patients we see in the ED, the more the system struggles to keep pace for all patients, and this then risks all patients’ experiences in the ED as long wait times ensue.

With respect to ED CAHPS, what would be nice is if there were a way to capture the experience of the “average” patient. At the end of the day, I don’t think the average patient’s experience is all that good, so it would benefit us to look to the data to see where we can improve. The average patient waits longer than he should, doesn’t get informed as much as he should, doesn’t leave with as much knowledge about the next steps in the care plan as we would like. The experience for the average patient has much room for improvement—we can and should do better. Yet, we have to be mindful of how practice can be affected when the experience of more challenging patient groups is included in the surveying. We have care plans in place for these patients, but often the plans do not align with what they are looking for. Ideally, we want our doctors to be able to say, “I’m sorry, but I can’t give you that drug or that treatment,” because it’s the right thing to do without worrying about patient complaints.

What I do see as incredibly valuable are the patient comments. We’ve just started giving faculty-specific feedback. The entire staff gets blinded comments, and those who are interested can quickly see what patients are not happy about. These can hit home, and they’re actionable. For example, one recent patient talked about her wound-packing instructions. It was a reminder that maybe we’re not paying enough attention to discharge instructions. The comments were specific (and embarrassing), and they will change behavior. The comments hit in a different way because you see yourself in them and feel passion for the patient experience.

*Partners*: What are some of the ED best practices you’ve identified or adopted that will help you meet the needs of your patients?

*Dr. Hamedani*: One of our most successful efforts has been the initiation of a pharmacist service in the ED. Our emergency medicine pharmacists review all of the electronic prescriptions generated by the ED physicians to prevent errors and streamline discharge education. Previously, the prescription process would contribute to discharge delay. The doctor would write the order for the prescriptions, then the nurse would gather the scripts and track down the doctor to sign them. Now, except for narcotics, the pharmacists take over the prescription process. They actually meet with the patients to go over the medications and answer any questions. This is a huge time-saver, because patients often have questions about timing of medication or contraindications that the doctors or nurses may not be able to answer. The pharmacists can also run queries on insurance coverage. This real-time intervention is important. Otherwise, patients might not realize until they take their prescription to the pharmacy that it’s not covered or that it’s too expensive, and they may forego care. Now, in real time, we can change meds and promote adherence.

Another process flow improvement has been the creation of a flexible care area that supports early patient evaluation and management during high volume periods through vertical patient flow. Basically, this care model challenges the assumption that every patient has to wait for a bed in the main department and can only be evaluated if they are horizontal and on their back in a traditional ED bed.

With vertical patient flow, care starts by segmenting patients who can be evaluated, managed, admitted or discharged safely without occupying a traditional ED room. The flexible care area has one doctor, nurse and technician assigned to the waiting room. They basically run through the list of patients in the waiting room to see if anyone can get started on tests or treatments. Given our boost in volume, we wouldn’t have survived if we didn’t have this up-front, early attention to rate-limiting steps in patient care. We needed a fast-track solution, but most of the models that have been implemented in other emergency settings were designed for low-acuity patients [Emergency Severity Index 4 and 5]. We don’t have that many ESI 4 and 5 patients. Our urgent care center takes those. The flexible care area can accommodate ESI 3 patients, which are two-thirds of our ED patients. Since the implementation, a lot of care happens there, and we have seen significant decreases in wait times.

*Partners*: Have any of your improvement efforts not worked out as you would have hoped?

*Dr. Hamedani*: Of course. Sometimes the best way to improve is to figure out what doesn’t work. We tried a strategy to help keep patients...
informed about delays. We actually hired staff to act as physician proxies to do rounds with patients to increase contact, but more often than not, the patients had more questions than the staff could answer. We also put up white boards that nursing and physician staff could use to tell patients what their care plan was and how long they might expect to be there, but we didn’t have great compliance. Depending on the situation, it can be really hard to estimate, and the boards were not getting updated.

**Partners:** What are the top three characteristics/personality traits that are absolutely essential to run an ED in today’s health care culture?

**Dr. Hamedani:** First, in the ED, you live in a fishbowl. You have to be comfortable with constant critical feedback and you have to be willing to listen to complaints. That’s the first step to making it better. You can’t be defensive. If someone doesn’t understand how things are done, explain it. Try to get a conversation going, and be ready to admit when the ED has done something wrong. More often than not, however, the person with the complaint comes to see the constraints under which care is provided in the ED and has new respect for the work that is being done.

Second, emergency medicine is a team sport, so you have to be a team player. The nature of the ED is such that you’re always in the position of asking for things from other people. Every day, being able to do your job requires asking for and getting things from other people, whether it’s a consult or an admission or just an extra pair of hands. So whenever you’re trying to make an operational change, you can’t have a personal agenda. You have to keep focused on the best interest of the patient. If you always focus on what makes sense for the patient, then when it comes time for some of the more difficult changes, if you haven’t deviated from that patient-centered mission, people will be more open to them.

Third, you have to be comfortable with constant change. That probably rules out a lot of people. You have no idea what’s coming—whether it’s a heart attack, a fish hook in an eyeball, or even a police shooting. You have to be ready and you have to constantly assess your resources and make split-second decisions. Beyond the constant variety of the patients, there is constant change in the department’s operations. As other clinical services change the care they give, it often impacts what is expected of the ED for the first couple hours of the patient’s care. We constantly modify, revise, and update our policies and procedures so that we can continue to provide the best care we can in partnership with the other clinical services.