California ED Diversion Project

Best Practice Initiative: Rapid Medical Examination

Hospital Name:
California Emergency Physicians

Address:
Multiple locations

Contact:
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2006 ED Volume: n/a
Growth from 2005: n/a
Total Staffed Hospital Beds: n/a
Acute ED Beds: n/a
Fast Track: n/a
Clinical Decision Unit: n/a

Problem to be Resolved:
Overcrowding due to lower-acuity patients.

Key Words:
- Rapid medical evaluation
- Virtual beds
- Waiting room
- Non-urgent patients
- Throughput
- Patient satisfaction

Lessons Learned:
Using patient tracking software along with RME makes the process even better, as it reduces any confusion about patient location and maximizes the patient flow process. Some CEP hospitals have not adopted patient tracking software, and still use a traditional white board to monitor patient flow. While CEP feels that this method is still acceptable; success can potentially be limited by the board not being kept up to date.

Reason for Change:

California Emergency Physicians (CEP) has had success with using rapid medical examination (RME) at many of its sites, inspiring others to try this process as well. Currently between one-third and one-half of CEP hospitals use RME.

Implementation:

California Emergency Physicians (CEP) has been using a rapid medical examination (RME) system, also known as "virtual beds," "outside waiting room," or "waiting room by appointment," at many of its facilities. Under a RME system, patients are identified who are likely to be discharged quickly. These patients are sent to a separate room for an examination and minor testing, rather than waiting in the waiting room. Once testing is complete, patients are either discharged or returned to the waiting room.

RME differs from the concept of a fast track unit, because in a fast track unit, lower acuity patients still must go through the same process as other ED patients. This process includes sign-in, MD evaluation, and registration, with one event happening after the other. In RME, on the other hand, some of those steps can be eliminated if they are not medically necessary. For example, a nurse's assessment may be skipped if it will not add anything to the patient's treatment. Also, some steps may be performed at the same time; for example, registration can be completed during the physician's examination.

Initially this approach caused some concern among ED nurses, who believed that they would need to monitor these patients while test results were pending. However, by focusing on truly non-urgent patients, they can completely eliminate the need for an RN in the process. Because RME patients do not need to be seen by a nurse, the RNs can focus their time and efforts on those who do need a nursing assessment, ongoing monitoring, and interventions. Many CEP hospitals using RME have changed their policies and procedures so that an NP, PA, or physician can see, treat, and discharge a patient without an RN.

Results/Impact:

Participating CEP EDs have seen a decrease in door-to-physician time, from an average of about 48 minutes to about 35 minutes. Patient satisfaction has increased at CEP EDs, with average satisfaction scores rising from 4.12 to 4.31 (out of five possible points).

Regional Medical Center of San Jose is an example of a CEP hospital that uses RME. The hospital began using RME in 2004, and saw substantial improvements in 2005. These improvements include decreasing the left without being seen (LWBS) rate from

seven percent to one percent and reducing diversion from over 60 hours per month to just four hours. Regional Medical Center was named CEP's "ED of the Year" in 2005.

Madera Community Hospital is another example of a CEP facility to have benefited from the use of RME. Madera saw a 37 percent decrease in door-to-physician time, going from 34 minutes to less than 10 minutes after implementing RME. Additionally, average length of stay for treat-and-release patients decreased from 175 minutes to 120 minutes, while the LWBS rate decreased from 4.2 percent to less than one percent. Patient satisfaction at Madera is now averaging 4.28 (out of 5), up from 3.96 in the year prior to RME.