Disclosures

Dr. Borger has nothing to disclose.
Rapid Medical Evaluation Success with Provider in Triage in High Volume Urban, Public, Teaching Hospital

- California Emergency Physicians
- Started implementing RME concept around 2003
- Very successful RME in small to medium size ED’s over 45
- Proved More Difficult in Large ED’s
- Multiple approaches needed
Sample Bar Chart

- St. Mary–Apple Valley: 1774, 2548
- Pioneer Memorial Hospital: 1647, 2433
- St. Bernardine Medical Center: 1870, 2843
- Madera Community Hospital: 1367, 2387
- Rideout Memorial Hospital: 1189, 2094

Year 2002 / Start of Contract
Current
CEPA Group Wide Experience

- 3 million patient visits Time To Provider to 20 minutes below national average
- Internal Expertise and Thought Leaders
- Model Best Practice Sharing
- Data Driven
- ED team integration and leadership
Arrowhead Regional Medical Center
Experience

- All the difficulties of a complex ED
- Large-130K visits 2009
- Psychiatric Receiving
- Teaching ED Residency established 2004
- Trauma Center, Burn Center, Neurosurgical Center
- Urban Poor and Public Hospital
LARGE VOLUME RME
GOALS

- Decrease Time to Provider
- Decrease Patient Elopements
- Increase Patient Satisfaction
- Decrease Ambulance Diversion
- Increase Patient Volume
LARGE VOLUME RME
GOALS

- Increase Patient Safety
- Improve Staff Retention
- Increase Provider-RN Teamwork
- Virtual ED Expansion
- Increased Hospital Revenue
FINANCE

- Will pay for itself
- Math is simple 20-40 LWBS
- Will bill for all LWBS and an increased volume
- Can not require more staffing or cost much despite having CEO or CFO support
- $60K
PLANNING

- Closed Process with six stakeholders
  - Registration, Nurse Manager, Assistant RN Manager, Physician Medical Director, DON, and Blessings and Support of ARMC CFO and CEO
  - Spent a lot of time chart flowing the process of the patient and the paper chart
  - Still just a theory
MOCK TRIAL

- Recruited about 30 volunteers
- Gave index cards with medical issues
- Cleared out the waiting room and designated treatment stations by placing tape on the floors
- Re-Grouped and re-evaluated flow process
ORDER FURNITURE

- Picked office style cubicles
  - Did not need OSHPOD approval
    - Our interpretation
    - Considered furniture
    - Mobile Computers
    - No patient care only initial intake
    - State surveyors signed off on the process
    - Initial privacy feel is very good
SECURITY

- Nursing Union “It’s unsafe being out there”
- Provider concerns
- Solution: Made the entire waiting room secure
  - Metal detectors
  - Large security presence
IMPLEMENTATION

- All Management on deck for the first week (Nursing & Physician)
- Process changes made but controlled
- Dealing with staff doing things differently
- Controlled Rapid Cycle Testing
NON-INTUITIVE RULES

- All providers MUST work a few shifts in RME per month
- Flow to the bottlenecks / Must have help flow from the back at times
- IT WILL WORK, no going back, one way
TRIAGE PROCESS

- Patient presents to ED ⇒ Seen by Intake Nurse

- Following Initial Assessment, Patient is either:
  - Escorted to Bed in ED
  - Referred to Registration Clerk

- From Registration Clerk, Patient ⇒ Triage Cubicle ⇒ Vitals ⇒ Seen by providers

- Provider determines:
  Further testing/Patient Disposition
Cubicle Screening

Initial Evaluation

Physician / Mid-level

Low Acuity
Discharge Home Following Registration

Diagnostics
(Radiology /Lab) Phlebotomist and/or Escort to Imaging

Higher Acuity
Immediate Bedding
MSE PROCESS

Labs and/or Radiology Completed

ETR returned to Resource Nurse

Second Physician Re-evaluates and determines disposition
PROCESS FLOW:
RESOURCE NURSE MONITORS
THROUGHPUT
New Processes and Culture Change:

Door to Doc time

- 2002: over 4 hours
- 2004: 120 minutes
- 2007: 50 - 60 minutes
- 2008: ~30 minutes average
- 2009: Sustained 30 minute goal
LWBS STATISTICS
2002 - 2008

- LWBS Response to Process Change:
  - 2002  20%
  - 2004  9%
  - 2006  2%
  - 2007  1.5 to 3.5%
  - 2008  Below 1% (May 2008)
  - 2009  Below 0.3%

- Combined with eloped for tracking still under 1%
Patient Satisfaction

- 99th percentile for teaching hospitals in waiting time
- 65-75th percentile overall
- Most improvement not in fast in and out patients but in the more seriously ill being seen quickly
Future Considerations

- Rapid Discharge
- Nursing Ratios and Provider Ratios
- Current Triage Severity Scores Functionally Meaningless
- Can this process be duplicated?
- Feed the Bears Phenomena