Rapid Medical Evaluation program reduces length of emergency department stay

LOWELL GENERAL HOSPITAL

Lowell struggled for several years with implementation of a fast track program that worked well for their Main Campus ED, which sees 60,000 visits for emergency services each year.

Challenge

For several years, they had a traditional fast track program, which separated the low-acuity patients out and tried to get them on their way faster than more complex patients who needed more time with providers. Despite implementing fast track, the ED continued to have capacity issues and so the ED team decided that they needed to consider other strategies to help improve patient flow.

Action

About four years ago, the ED leadership team collectively decided to implement a Rapid Medical Evaluation (RME) program in the ED to help manage patient flow by having a provider available at triage to assess and treat low-acuity patients. At first, the RME program was not very effective. It was poorly organized, lacked clear guidelines and did not have a dedicated team or space. The ED staff didn't like it and initially it created flow problems rather than helping to solve them.

In response to these challenges, the team worked to make adjustments to the RME program in 2017 to add structure and improve its operational efficiency, which has led to better outcomes. One challenge initially was that RME was not a regular, every day program and so providers would be pulled from their shift to work the program. The ED team changed that structure, making it a program that operates on a predictable, daily schedule and with a dedicated two-person team including a mid-level provider (NP or PA) and a tech.

The tech position is critical, because s/he is responsible for a number of activities, including moving patients around the RME space, getting specimens, and assisting with splinting. In addition, the ED created a dedicated space for the RME team to operate that includes 6 beds. Finally, the ED established and implemented clear, very strict patient eligibility guidelines to help determine who was appropriate to be seen in RME. This meant excluding patients who needed anything else that is too involved, such as sutures or procedures, so it was "only the quickest of the quick," according to Dr. Nathan MacDonald, the Chief of Emergency Medicine. To make sure they are maintaining fidelity to the processes set up, the team collects throughput data on all providers and analyzes it monthly.

Outcomes and lessons learned

Since relaunching RME in March 2017, the ED team has seen marked improvements in several outcomes in the ED. The hospital has been able to document a decrease in ED length of stay for RME and traditional ED patients as well as a reduction in the number of patients who leave without being seen. Not surprisingly, patient satisfaction scores have improved, and the better flow makes for a happier ED staff as well.

In order to achieve these successes, the ED had to get some limited buy-in from other departments in order to change some physical aspects of the ED and also to alter the registration process. For RME patients, registration needed to be expedited, because the patient would be expected to spend less time in the ED. Overall, though, most of the project required changes within the ED itself and required engagement with ED staff.

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