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Operations of Select Fast Track EDs

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RESEARCH IN BRIEF

Fast track emergency departments (EDs) allow hospital administrators to expedite patient throughput in the ED by isolating patients with lesser acuity and assigning their care to a team appropriately trained to treat such patients. Typically, physician assistants (PAs) are tasked with evaluating and treating fast track patients with the support of a registered nurse (RN) and an ED technician (tech). The coordination of ancillary services is typically the greatest limiting factor in achieving door-to-discharge goals, and administrators at some facilities have established dedicated X-ray areas and other ancillary suites to overcome this challenge. This brief examines the operations of fast track EDs at four institutions.

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I. RESEARCH METHODOLOGY

The findings detailed in this report were drawn from literature and interviews with the following sources:

Institution	Annual emergency department (ED) visits	Hours open per day	Separate fast track triage	Fast track team	Bedside registration	Patient satisfaction tracking
Hospital A 300-bed, not-for-profit community hospital located in the Midwest	50,000 (10,000 fast track)	12	No	<ul style="list-style-type: none"> Family practice (FP) physician Registered nurse (RN) Technician (tech) 	All ED patients	<ul style="list-style-type: none"> Fast track patients not tracked separately Survey developed by national organization
Hospital B 100-bed, not-for-profit community hospital located in the South	28,000 (9,000 fast track)	12	No	<ul style="list-style-type: none"> Physician's assistant (PA) RN or licensed practical nurse (LPN) Tech 	All ED patients	<ul style="list-style-type: none"> Fast track patients not tracked separately Survey developed in-house
Hospital C 200-bed, not-for-profit community hospital located in the Midwest	28,000 (9,000 fast track)	12	Yes	<ul style="list-style-type: none"> RN Secretary Tech Triage RN 	All ED patients	<ul style="list-style-type: none"> Fast track patients not tracked separately Survey developed by national organization
Hospital D 100-bed, not-for-profit community hospital located in the South	42,000 (14,000 fast track)	12	No	<ul style="list-style-type: none"> PA RN Tech 	Only fast track patients	<ul style="list-style-type: none"> Comment boxes throughout ED Fast track patients not tracked separately

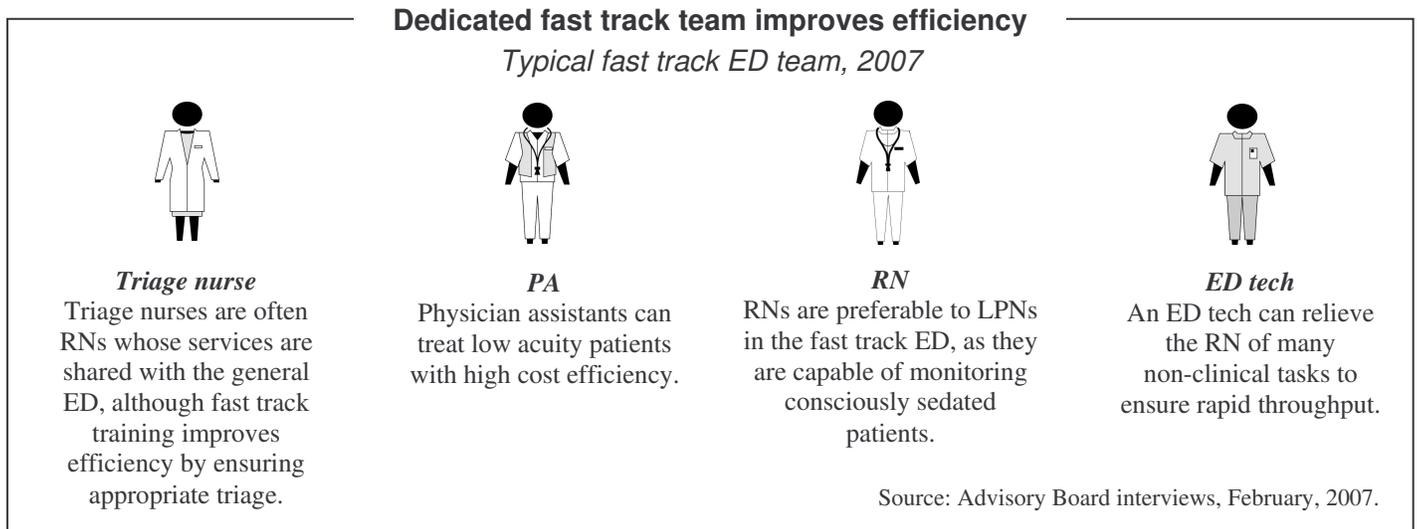
II. INTRODUCTION

Fast track EDs designed to maximize throughput, improve overall ED efficiency

Fast track emergency departments (EDs) consistently allow hospital administrators to increase ED throughput for all patients by separating the treatment process for low-acuity patients. As a result, ED physicians can focus their efforts on treating more acute patients, while a dedicated fast track team can maximize the efficiency of treating patients of lesser acuity. Typically, fast track EDs are open for the general ED's busiest twelve hours—usually beginning in the late morning to early afternoon—to ensure maximum impact of the model. Approximately one-fourth to one-third of ED patients are treated in the fast track programs at the contacted facilities and administrators set one hour door-to-discharge target times for these patients. Even when this goal is unmet, overall ED efficiency is significantly improved with the addition of a fast track program and thus patient satisfaction is typically high.

III. FAST TRACK ED STAFFING

Appropriate staffing is critical to the overall success of a fast track ED. Generally, a dedicated team can efficiently treat fast track patients more readily than if staffing is shared with the main ED, as the dedicated team can focus their efforts on rapid throughput for patients with minor complaints. Because fast track patients are of low acuity and complexity, a PA or nurse practitioner (NP) can often be employed as the primary care provider. Support staff can then be utilized to carry out orders following a PA's or NP's evaluation. The graphic below shows a fast track ED team typical of contacted facilities.



Physician staffing in fast track ED expensive, challenging

Hospital administrators often elect to adjust the general staffing model to suit the needs of their specific patient population. For example, administrators at Hospital B often utilize LPNs as they have a shortage of RNs in their service area. While the arrangement is not ideal due to restrictions placed on LPNs for monitoring consciously-sedated patients—who are common in the fast track ED—administrators find that the fast track ED still significantly improves overall efficiency. Administrators at Hospital A are also working with an altered fast track staffing structure, as shown in the case study below.

Case study: FP physicians provide fast track care, create scheduling concerns

Administrators at Hospital A have worked to include dedicated FP physicians in the fast track ED since the outset of its development. While general ED physicians are employed by the hospital, administrators are attempting to contract with FP physicians for the fast track. Currently, only half of fast track shifts are covered by a FP physician due to administrators' inability to identify area physicians willing to sacrifice time in their private practice. In the near future, administrators will evaluate potential strategies to add more FP physicians to the fast track rotation.

Source: Advisory Board interviews, February 2007.

IV. TACTICS TO OVERCOME FAST TRACK ED CHALLENGES

As the primary goal of fast track EDs is to maximize ED patient throughput, administrators typically measure program success by tracking the average door-to-discharge times against a set goal—almost always one hour. Consistently meeting the one hour goal is challenging in many cases as it typically requires streamlined processes from triage and registration through diagnostic testing and discharge.

Recommendation #1—Prioritize triage process as first step to achieving maximum efficiency.

Appropriate triage is the first step to ensuring the efficiency of a fast track program is maximized. A higher acuity patient triaged to the fast track can have significant downstream effects by occupying both bed space and staff members' time for an extended period of time. Administrators at all profiled facilities work to ensure appropriate triage by providing triage RNs with set criteria for fast track patients, although Hospital C is the only facility with a separate fast track triage station. Generally, the established triage guidelines are adequate; however, administrators at Hospital C find they have better triage accuracy with an independent triage station. Administrators at Hospital A have developed a protocol for patients mistriaged to the fast track, as shown in the case study below.

Case study: Patients inappropriately triaged to fast track transferred back to main ED

Administrators at Hospital A observed that mistriaged patients were hindering fast track ED by occupying bed space and providers' time. To overcome the challenge, they first developed specific triage guidelines to ensure triage nurses could identify patients appropriate for the fast track ED. Additionally, administrators set a policy whereby patients admitted to the fast track and later determined to have a level of complexity or acuity beyond the scope of fast track care are now transferred back to the main ED. If no beds are available for the transfer, the patients may be returned to the waiting area. As a result of the protocol updates, nearly all patients are discharged within the one hour door-to-discharge goal.

Source: Advisory Board interviews, February 2007.

Recommendation #2—Use bedside registration to speed ED patient throughput, expedite fast track care.

Similar to its potential effects in a general ED, bedside registration is a valuable method for improving patient throughput in the fast track ED as it permits patients to be evaluated without delay. Minimizing delays to evaluation is especially important in the fast track, where staff are working to have patients discharged within an hour of their presentation at the hospital. Administrators at all contacted facilities utilize bedside registration for their fast track patients, and only administrators at Hospital D fail to use bedside registration for their main ED patients.

Recommendation #3—Coordinate ancillary services to reduce wait times for low acuity patients.

As a result of the tight evaluation and treatment deadline in fast track EDs, the coordination of ancillary services is vital to maximizing throughput and meeting one hour door-to-discharge goals. Immediate access to ancillary services may be especially challenging for fast track patients as they are of generally low acuity and thus have a lower diagnostic priority than general ED patients. Administrators at Hospital B are working to address such a challenge in obtaining radiology and other ancillary services quickly for fast track patients. Currently, they report that many fast track patients have door-to-discharge times near two hours as a result of the difficulties. Similarly, administrators at Hospital D note that ancillary services often hinder their throughput. Strategies to overcome these challenges may be found in processes developed at Hospital A and Hospital C, as demonstrated in the case studies below.

Dedicated fast track services reduce ancillary service complications

Case studies of fast track ED ancillary service strategies, 2007

Case study: Administrators at Hospital A assign portable X-ray machines to streamline imaging for fast track patients

Hospital A administrators recognized the difficulty of securing ancillary services for fast track patients early in the development of their fast track ED.

To overcome this challenge and ensure maximum throughput, they decided to make a portable X-ray machine available to fast track ED patients. As a result, patient throughput improved because fast track patients no longer wait behind more acute main ED patients for the imaging services most utilized in the fast track.

Case study: Hospital C administrators include dedicated X-ray suite to ensure rapid evaluation of fast track patients

Administrators at Hospital C recently built a new ED that included a physically separated fast track suite.

As a strategy to maximize fast track throughput, the new fast track ED includes many dedicated ancillary services, including an X-ray suite. As a result, the majority of the fast track team is able to consistently meet the one hour door-to-discharge goal set by hospital administrators for the treatment of fast track patients.

Source: Advisory Board interviews, February 2007.

Research Methodology

During the course of research, Original Inquiry staff searched the following resources to identify pertinent information:

- Advisory Board's internal and online (www.advisory.com) research libraries
- American Hospital Association (AHA), *Healthcare Quickdisc*[®], 2006
- EBSCO[®] Health Business FullTEXT[™]
- Factiva[™], a Dow Jones company
- Internet, via search engines and multiple websites, including the following:
 - ✓ American Academy of Emergency Medicine (AAEM) at www.aaem.org
 - ✓ Emergency Nurses Association (ENA) at www.ena.org
 - ✓ *Journal of Emergency Nursing* (JEN) at www.ena.org/publications/jen
 - ✓ National Emergency Medicine Association (NEMA) at www.nemahealth.org
 - ✓ Society for Emergency Medicine Physician Assistants (SEMPA) at www.sempa.org
 - ✓ Various hospital and health system websites

Based on leads generated from the above sources, researchers contacted hospital administrators to discuss the operations of fast-track EDs.

Professional Services Note

The Advisory Board has worked to ensure the accuracy of the information it provides to its members. This project relies on data obtained from many sources, however, and the Advisory Board cannot guarantee the accuracy of the information or its analysis in all cases. Further, the Advisory Board is not engaged in rendering clinical, legal, accounting, or other professional services. Its projects should not be construed as professional advice on any particular set of facts or circumstances. Especially with respect to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this project. Neither the Advisory Board Company nor its programs are responsible for any claims or losses that may arise from any errors or omissions in their projects, whether caused by the Advisory Board Company or its sources. 1-ML4VJ

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