HealthLeaders Media | Intelligence

FREE REPORT

MAY 2014

The ED Fix:

Triage, Coordination, and Navigation

An independent HealthLeaders Media Survey supported by

TeleTracking®

Powered by

HEALTHLEADERS MEDIA Council
Access. Insight. Analysis.

The ED Fix:
Triage, Coordination, and Navigation

This report uncovers emerging best practices in care team composition and patient flow to improve ED throughput and patient satisfaction.

- Find out which ED performance tactics are most relevant to accelerating patient flow and driving improvements
- Learn how Texas Health Harris Methodist Hospital's four-category triage and "hallway protocol" have helped to keep average door-to-doctor time at 15 minutes
- Discover how the use of hallway beds on hospital floors can speed care and improve patient satisfaction
- Learn how Montefiore Health System works to reduce future non-emergent ED visits by helping the 30% of patients without primary care relationships transition to PCPs for subsequent care
- Compare ED performance practices and plans to learn the most effective (and non-effective) strategies for volume management
- Deep-dive into over 400 charts with segmented peer data

PERSPECTIVE

A Wake-up Call for America's EDs

Overcrowding in America's emergency departments is largely the result of a capacity issue in the rest of the hospital. In addition, patient logjams due to outdated flow procedures keep ED patients waiting too long for rooms, putting undue stress on them and their ED care providers.

These factors have been recognized by the Government Accountability Office, the Institute of Medicine, and The Joint Commission. Now, senior healthcare leaders are also acknowledging that fact, according to the HealthLeaders Media survey published in this Intelligence Report.

Nevertheless, healthcare leaders remain focused on "fixing" the ED, even as volumes continue to rise.

According to the survey, the most common ED investment over the next three years will be additional FTEs: mostly ED physicians, nurses, or midlevel professionals. Yet the respondents say patient flow and boarding are two of the greatest challenges facing their emergency rooms.

More than half of respondents say overcrowding is a regular problem and 65% expect ED volumes to increase in the next three years while more than half predict a fall in ED reimbursement (70%) and margins (59%). Yet, despite this, an even greater majority (79%) expects ED quality outcomes to increase.

When asked to select the factors that present the biggest bottleneck problems for ED flow, 61% of respondents cite ED-to-inpatient transfers, making it far and away the dominant obstacle.

This makes one wonder why new hiring is the top priority over the next three years when patient flow is recognized as one of the ED's biggest problems and ED-to-inpatient transfers produce the biggest patient flow bottlenecks.

In fairness, 40% said information technology will be a large investment, but IT focused primarily on the ED will not create the available "space" in the rest of the hospital needed to ease overcrowding.

Two other recent reports predict the problems in America's emergency departments will only get worse if nothing is done about overcrowding.

The first, the National Report Card by the American College of Emergency Physicians, gave U.S. emergency care a "D-minus" regarding access to emergency treatment. The ACEP report said the problem is "too few emergency departments to meet the needs of a growing, aging population and of the increasing number of people now insured as a result of the Affordable Care Act."

According to the other study, *Medicaid Increases Emergency Department Use: Evidence from Oregon's Health Insurance Experiment*, newly insured individuals

Perspective (continued)

actually use emergency departments 40% more often than their uninsured counterparts, in complete contradiction of predictions regarding the short-term impact of the Affordable Care Act.

Effective overcrowding solutions already exist. Automated, real-time healthcare operations management has been proven to optimize existing capacity by taking wasted time out of the patient flow continuum. This process dramatically improves patient flow throughout the facility, allowing emergency department overcrowding to be sharply reduced.

Nearly 900 of the nation's 5,000 hospitals already have installed real-time, systemwide automated control systems to expedite patient movement, identify open beds, find medical equipment, and avoid flow bottlenecks.

With waves of aging baby boomers and the newly insured advancing on the nation's EDs, it's time for a wake-up call. We sincerely hope this survey helps to initiate that call.

Nanne Finis, RN, MS
Vice President
TeleTracking Consulting Services
Pittsburgh

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the May 2014 HealthLeaders Media Intelligence Report. In the full report, you'll find a wealth of additional information, including segmented data. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system), number of beds (hospitals), number of sites (health systems), net patient revenue, region, and ED overcrowding status.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by Peter P. Semczuk, DDS, MPH, Vice President of Clinical Services, Moses-CHAM Campus, Montefiore Medical Center, Bronx, N.Y., and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Presbyterian Healthcare Services in Albuquerque, N.M.; Texas Health Harris Methodist Hospital Fort Worth; and Montefiore Health System in Bronx, N.Y.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

Table of Contents

Methodology

The ***2014 ED Strategies Study*** was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In February 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience from hospitals or health systems. A total of 407 completed surveys are included in the analysis. The bases for the individual questions range from 335 to 407 depending on whether respondents had the knowledge to provide an answer to a given question. The margin of error for a sample size of 407 is +/-4.9% at the 95% confidence interval.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

Joseph S. Prosser, MD, MBA, CPE, FACPE
Vice President and Chief Medical Officer
Texas Health Harris Methodist Hospital Fort Worth and the system's Azle, Cleburne, and Specialty Hospital facilities

Judy Horton, RN
Director of Emergency Nursing Services
Texas Health Harris Methodist Hospital Fort Worth

Darren Shafer, DO
Service Line Medical Director of Emergency Medicine, Urgent Care, and Albuquerque Ambulance Service
Presbyterian Healthcare Services
Albuquerque, N.M.

Peter P. Semczuk, DDS, MPH
Vice President of Clinical Services
Moses-CHAM Campus
Montefiore Medical Center
Bronx, N.Y.

UPCOMING INTELLIGENCE REPORT TOPICS

JUNE
Cost Containment & Revenue Cycle Management

JULY
Clinical Quality & Safety

AUGUST
Patient Experience

SEPTEMBER
Physician-Hospital Alignment

OCTOBER
Population Health Management

NOVEMBER
Executive Compensation

Click here to subscribe.

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

HealthLeaders Media

Intelligence Report Research Analyst
MICHAEL ZEIS
mzeis@healthleadersmedia.com

Vice President and Publisher
RAFAEL CARDOSO
rcardoso@healthleadersmedia.com

Editorial Director
EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bwertz@healthleadersmedia.com

Intelligence Unit Director
ANN MACKAY
amackay@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

Intelligence Report Contributing Editor
MARGARET DICK TOCKNELL
mtocknell@healthleadersmedia.com

Intelligence Report Contributing Editor
JACQUELINE FELLOWS
jfellows@healthleadersmedia.com

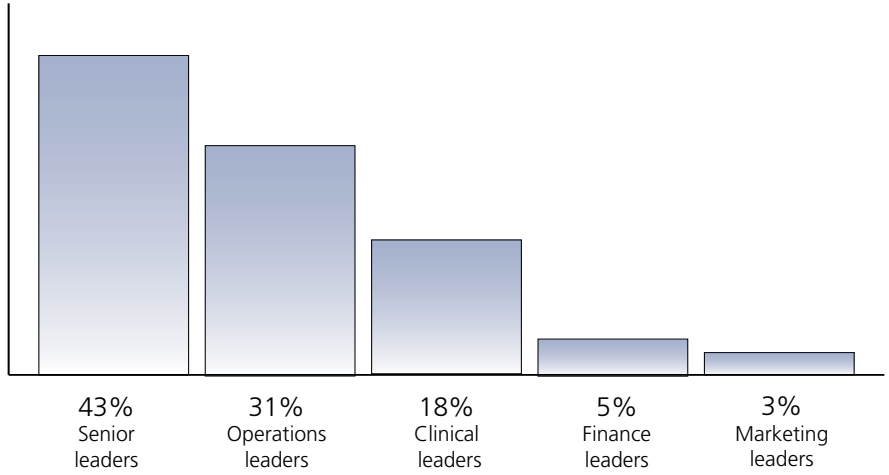
Intelligence Report Design and Layout
KEN NEWMAN
knewman@healthleadersmedia.com

Respondent Profile

Respondents represent titles from across the various functions at at hospitals and health systems.

Title

Base = 407



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director,VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Finance leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Type of organization

Base = 407

Hospital	74%
Health system	26%

Number of beds

Base = 301 (Hospitals)

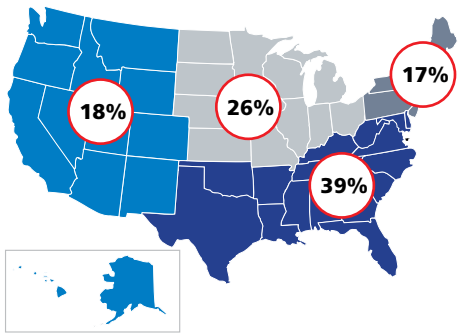
1–199	51%
200–499	35%
500+	14%

Number of sites

Base =106 (Health systems)

1–5	21%
6–20	37%
21+	42%

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

ANALYSIS

Improving Care Team Composition and Optimizing Patient Flow In the ED

MICHAEL ZEIS

Much of what happens in the emergency department is related to how many and what kind of patients come through the doors. And while patient volume and acuity may be predictable, to an extent, for the most part, those are factors that the ED team cannot fully control. But with proper preparation, an effective ED response can ensure optimal outcomes, improved patient satisfaction, and efficient throughput with reduced wait times.

"I divide factors that contribute to wait times into two categories: those which the ED can control and those which it can't," says Darren Shafer, DO, the service line medical director of emergency medicine, urgent care, and the Albuquerque Ambulance Service for Albuquerque, N.M.–based eight-hospital Presbyterian Healthcare Services.

One-quarter of the respondents to the *2014 HealthLeaders Media Survey on ED Strategies* (25%) report annual visits in excess of 70,000 patients. That includes 43% of health systems but only 17% of hospitals. Facility size certainly is a factor: More than half of large hospitals (51%) see more than 70,000 patients per year in their EDs. Overall, more than half (55%) say their ED is always or often overcrowded. Like volume, overcrowding is size-related: 71% of respondents from organizations with net patient revenue of $1 billion or more say their ED is always or often overcrowded.

WHAT HEALTHCARE LEADERS ARE SAYING

"We have an RN for triage and rooming is within 5 minutes; physician screening is within 15 minutes. Door to discharge is less than 2 hours for minor complaints and less than 3 three hours overall. Door to admission is less than 4 hours."

—CEO at a medium hospital

"We have 24-hour triage nurse coverage with a second triage nurse assigned at least 12–16 hours per day. We try to triage in a treatment room rather than bottleneck in the triage room (i.e., immediate bedding). Triage can be performed in the room by any nurse, not just the assigned triage nurse. We have actually retermed our triage nurses as patient flow coordinators."

—Chief nursing officer at a medium hospital

"Patients are taken directly to a bed if one is open, and registration occurs there."

—Chief medical officer at a medium health system

"We have one triage nurse. Admitting gets minimal information. The patient then goes to triage and if a room is available they go straight back. If nonemergent, they go to the waiting room."

—Chief nursing officer at a medium hospital

"A greeter immediately beds the patient. No 'triage' if there isn't anyone to triage. If patients begin to queue, then an RN assigns triage acuity and directs patient flow. In some EDs, mid-levels in the greet area begin treatment."

—Director of quality at a large health system

Analysis (continued)

Longer wait times are one consequence of overcrowding. While one-fifth of all respondents (19%) report an average time patients spend in the ED before being seen by a healthcare professional of less than 15 minutes, in EDs characterized as always or often overcrowded, the average time patients spend in the ED before being seen by a healthcare professional is 46 minutes. In EDs characterized as occasionally, rarely, or never overcrowded, average waits are 23 minutes.

Because there is an element of unpredictability about patient volumes, there also is an element of unpredictability about wait times. But unlike patient volume, there are many ways to address wait times. Here's why ED leaders pay a lot of attention to wait times: "Even if a patient is not back in a bed, for instance, if they're in our waiting area and not being seen by a doctor, they're still our responsibility," says Judy Horton, RN, director of emergency services for the 726-bed Texas Health Harris Methodist Hospital Fort Worth.

Peter P. Semczuk, DDS, MPH, vice president of clinical services at Bronx, N.Y.–based Montefiore Medical Center, which operates six hospitals on five campuses and more than 140 community-based sites throughout the Bronx and Westchester County, including the 767-bed Montefiore Medical Center, says, "One of the things that keeps me up at night, that's absolutely top of mind, that I worry about all the time, is patients that are left in the waiting room. It really frightens me because bad things happen to patients in waiting rooms. We want you inside, around the clinical team that's caring for you."

> "I divide factors that contribute to wait times into two categories: those which the ED can control and those which it can't."
>
> —Darren Shafer, DO

Joseph S. Prosser, MD, MBA, CPE, FACPE, vice president and chief medical officer of Texas Health Harris Methodist Hospital Fort Worth and three other hospitals in the Texas Health Resources system, conveys a similar sentiment: "Our mission is to have no patient wait in the waiting room."

At Montefiore and elsewhere, stationing experienced clinical staffers right in the waiting room is a way of ensuring that those who need care the most will get timely attention. "We think the triage process should begin in the waiting room," says Montefiore's Semczuk. "I think that is the single-most important thing that we can do as ED leaders to increase efficiency." Doing triage in the waiting room has another benefit besides launching patient flow and treatment. "The biggest benefit," he observes, "is you've got someone watching patients all the time while they're waiting."

Analysis (continued)

Focus on patient flow. One way or another, care at virtually all EDs starts with triage. Nearly three-quarters of respondents (72%) say their triage activity supports ED throughput efficiency. Streamlined registration (63%) and channeling low-acuity patients to a fast-track area (65%) are other leading techniques to increase throughput efficiency.

On the top of the list of efficiency techniques to institute next: 38% expect to speed up transfers for patients to be admitted. ED-to-inpatient transfer is the bottleneck identified most frequently, by 61% of survey respondents, including 69% of those who characterize their ED as always or often overcrowded. "If I look back at the challenging cases we've had in the last year or so, almost every single one of them have to do with an admitted patient that was waiting a prolonged period of time for an inpatient bed," says Semczuk, lead advisor for this Intelligence Report.

Prosser from Texas Health Harris Methodist Hospital Fort Worth says its team pursues transfer or discharge from the very beginning: "We are doing discharge planning from the moment a patient comes in the emergency room." To make room for more ED patients when inpatient occupancy is high, Texas Health admits certain patients who then occupy screened-off hallway beds. Says Prosser, an advisor for this report, "That way we can get a patient out of the emergency department and take them up to the floor until a bed opens up. The patients actually want to do that—they want to get out of the emergency room and upstairs in the hospital where they're being managed by nurses and staff that are familiar with their pathophysiology."

> "Even if a patient is not back in a bed, for instance, if they're in our waiting area and not being seen by a doctor, they're still our responsibility."
>
> —Judy Horton, RN

Staffing for patient care and throughput. Semczuk sees the trend toward using more midlevels, nurses, physician assistants, and allied health professionals for patient care in EDs, and says, "I think it's a mistake." About a decade ago, Semczuk says that Montefiore recognized that "many of the people that were seeing sick patients in our ED were people who had full-time jobs as hospitalists or internists or nurse practitioners. [We felt that] those who were not trained in emergency medicine were not investing the time and effort to learn emergency medicine. What we needed to do was to staff our emergency departments with residency-trained emergency medicine physicians. Now patients know that if they come here, they're going to be seen by a board-certified emergency medicine physician who has dedicated his or her life to this field. They're not going to be seen by someone who happens to work a shift that day in the emergency department." (Montefiore is the academic medical center and university

Analysis (continued)

hospital for Albert Einstein College of Medicine, and offers a four-year residency in emergency medicine.)

Nonetheless, 46% expect to invest in midlevel caregivers for their EDs within the next three years, nearly twice as many who expect to invest in physician staff (25%). Shafer, from Presbyterian Healthcare Services, offers this perspective: "Midlevels may not be able to see patients with quite the same acuity as a physician would, but by having them here, we can greatly extend the ability of the physician to cover more patients. Because it's going to be a cost savings, in healthcare we're going to see it more and more. The way the economics are, that's the future."

Semczuk reminds us, though, that those who have specific training can be very productive. "I encourage leaders to think about hiring more doctors at the expense of the midlevels. Doctors are incredibly productive when they're working in an emergency room setting if they're board-certified—they could easily see three or four patients an hour."

Redirection for non-emergent patients. Another way to foster efficient throughput is to minimize the number of non-emergent patients who visit EDs. At the top of the list of tactics to minimizing avoidable ED visits is limiting prescriptions for opioids, a method used by 66%. In addition, nearly half (45%) track patients who visit EDs seeking opioid prescriptions. More than half (54%) help minimize avoidable ED visits through better coordination with primary care practices and clinics.

One quarter (24%) redirect non-emergent patients, and 29% say that they expect to begin redirecting non-emergent patients within the next three years. Care coordinators and patient navigators are one way to accomplish redirection. Shafer explains, "Not only do our navigators work within our system, but they also are in touch with all the other clinics in the city—low cost, no cost, or physicians starting up a private practice. They find out who's got any capacity to see patients and which patients they are taking." Shafer admits that referring non-emergent patients without insurance or who otherwise have no ability to pay for care presents a problem. "We have to be cautious," he says. "We might have to absorb that cost within our own healthcare system."

> "Our mission is to have no patient wait in the waiting room."
>
> —Joseph S. Prosser, MD, MBA, CPE, FACPE

Shafer notes that navigator follow-through ensures that physicians accept the concept of redirecting non-emergent patients. "As physicians in the emergency department, a doctor will worry that this is our one chance to make the diagnosis on a patient, so we might order a full set of labs and other tests. However, if we know the patient is going to be seen

Analysis (continued)

and evaluated by another set of medical eyes within the next 12 to 24 hours, and continuity of care is going to be established with that patient, we don't need to do as intense a workup in the ED because we know that that's going to be taken care of."

Working closer with the continuum of care. Healthcare leaders endorse communication as a way of fostering relationships along the continuum of care. Two-thirds (68%) are improving or expect to improve communications with primary care practices. And 61% are improving communication about their patients through improved integration of care partners' EHRs.

One-third of EDs (33%) have a strong working relationship with community-based clinics, a slight increase over last year's 28%.

Texas Health is in the booming Dallas-Fort Worth area, and the increased demand for healthcare that is accompanying population growth is straining primary care capacity at the same time it is increasing ED volume. Says Prosser, "Conceptually, if people are educated that they have other avenues of care, then they're going to choose those avenues rather than come to an emergency room and sit around for several hours. But part of the challenge in our community is that the primary care physicians are already busy, and by the sheer population growth, demand is outstripping supply, so patients have trouble getting into primary care offices."

Investments to enhance care. Prosser notes that smooth transfers are a benefit of closer working relationships with care continuum partners. "We have worked with some of our postacute facilities to improve communications so that they will accept patients in transfer more readily, and with [EHR] information exchange, patient transfer is smoother and more efficient."

> "We think the triage process should begin in the waiting room. I think that is the single-most important thing that we can do as ED leaders to increase efficiency."
>
> —Peter P. Semczuk, DDS, MPH

Shafer says information enhances care partnerships, fostering teamwork. "With EHRs, primary care providers can see exactly what happened in the emergency department. They see what tests were done, so they don't have to repeat any tests. If a diagnosis wasn't made and the patient was merely stabilized, they can see exactly what the next steps are in terms of the workup. This way, the ER becomes a full team member in care, whereas previously it was more episodic, and the ER didn't know what was going on in primary care."

Analysis (continued)

Information technology helps EDs track performance and track patient status. Overall, 40% of survey respondents expect to make ED-related IT investments over the next three years. Says Semczuk, "We collect some 40 different indicators on our ED performance. I cannot imagine managing 370,000 visits a year without having a lot of data at my disposal because, without measuring it, we can't manage it." Making decisions and providing care in such a fast-changing environment can be aided by tracking real-time status of the in-ED patient population. Says Prosser, "In our emergency room, computer screens show who's been registered but hasn't been seen. Physicians either see those people or they mark on the computer that they're the next one in."

Telemedicine is finding a place in EDs, too, with 36% expecting to invest in it. At Presbyterian, telemedicine helps support behavioral health assessments and diagnoses, which is significant, given that 49% of survey respondents indicate that psychiatric patients occupying beds represent a major source of ED bottlenecks. Shafer describes how telemedicine helps: "Behavioral health patients can take up a tremendous amount of time in the emergency department. You can be holding a bed for hours and hours when you haven't made a disposition, and you have to get a consult done. Finding someone to be able to do that consult can be really challenging." (Of course, behavioral health patients often linger in the ED after the diagnosis has been made, because of an industrywide shortage of inpatient behavioral health beds.) Although Presbyterian finds telemedicine helpful in certain cases, long-distance consultations are not for everyone. Says Prosser of Texas Health, "To be honest with you, our specialists who are on call certainly have mixed feelings about taking care of people several hundred miles away by looking at a picture."

> "We are doing discharge planning from the moment a patient comes in the emergency room."
>
> —Joseph S. Prosser, MD, MBA, CPE, FACPE

Some busy EDs can remove a bottleneck if they have an in-ED pharmacy, but the ED has to be busy enough. Overall, only 11% intend to invest in an in-ED pharmacy, indicating that for many, the level of service from their existing pharmacy setup is suitable. In-ED labs (9%) and imaging (8%) have similarly low readings. Fourteen percent of those whose EDs are always or usually overcrowded intend to invest in an in-ED pharmacy, compared to 8% of those whose EDs are occasionally, rarely, or never overcrowded.

Analysis (continued)

Capital investment decisions are more complex than decisions that are more operations-specific. Population gains and an aging facility convinced Texas Health to build a new ED, the Marion Emergency Care Center, with 100 patient beds and in-ED imaging, which opened in January 2014. "The needs of our patients really drove that," Prosser says. "Our legacy emergency department was woefully inadequate for the increase in patient demands, patient volume, and the complexity of the patients we receive." Texas Health operates a Level II trauma center. The Texas Health Harris Methodist Hospital Fort Worth operates an off-site ED as well, and a second off-site ED is under construction.

Quality is the goal. Patient flow is the method. Without a doubt, successful EDs pay attention to patient flow from every possible direction. Semczuk monitors 40 ED metrics, for example, to help keep his waiting rooms empty. Although focus and attention to detail are required to optimize processes, Shafer reminds us that quality of care can serve as an overarching discipline for ED executives.

"We want to make sure that we're getting patients in and moved as quickly as possible, and that relates to quality. If our beds are occupied, we have more patients who leave without being seen, more leaving against medical advice. If we have delays getting patients out of the ED and into the inpatient setting, we have nurses who are not accustomed to doing floor orders actually providing care for patients right in the emergency department. You worry about potential mistakes, because they're giving medications they don't normally give." Shafer notes that risks are especially high when a patient destined for an ICU is held in the ED, because of the difference in patient-nurse ratio. "We have a 4:1 ratio in the emergency department, but in the ICU they have a 2:1 or a 1:1 ratio."

> "Midlevels may not be able to see patients with quite the same acuity as a physician would, but by having them here, we can greatly extend the ability of the physician to cover more patients."
>
> —Darren Shafer, DO

Of course, patients are more satisfied when patient flow works smoothly. "The longer patients wait in the emergency department for a bed," Shafer states, "the more dissatisfied they're going to get. That's going to hit the HCAHPS scores, which can affect financial return."

Analysis (continued)

Conversely, Shafer notes that patients benefit from an ED that moves them along. "There is a certain efficiency in getting the patient in, getting them assessed quickly, getting their treatment initiated quickly and managed either into the hospital or to a postdischarge setting. All of this drives a certain measure of patient satisfaction, because they got in quickly and we figured out what was wrong, and got them on the right path. All of it comes into play—we have to do the right thing from a patient-safety perspective, from a risk perspective, from a quality perspective, while considering finance and satisfaction, too. That makes up the whole of it."

Michael Zeis is research analyst for HealthLeaders Media.
He may be contacted at mzeis@healthleadersmedia.com.

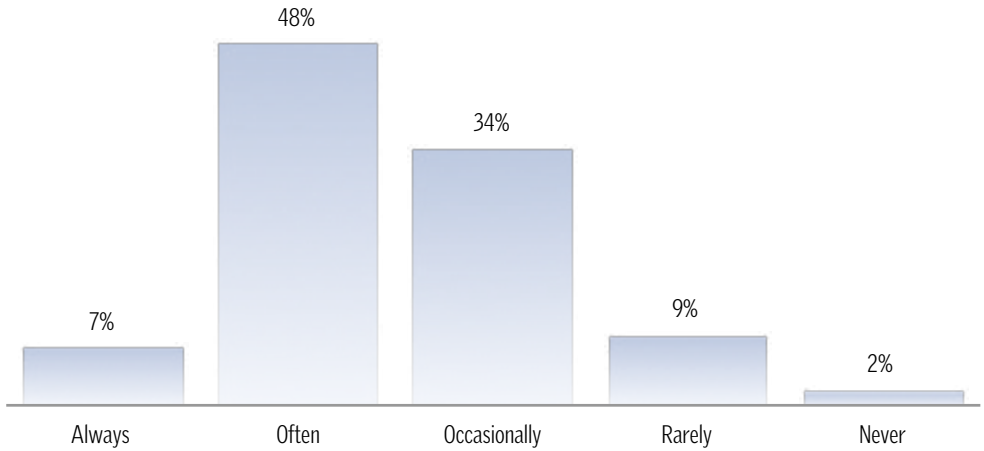
"We collect some 40 different indicators on our ED performance. I cannot imagine managing 370,000 visits a year without having a lot of data at my disposal because, without measuring it, we can't manage it."

—Peter P. Semczuk, DDS, MPH

FIGURE 1 | ED Overcrowding

Q | How often is your ED overcrowded?

Total responses



TAKEAWAYS

- A higher percentage of health systems (66%) than hospitals (52%) have EDs that are often or always overcrowded.
- Nearly three-quarters of respondents from organizations with at least $1 billion in net patient revenue (71%) characterize their EDs as always or often overcrowded, compared to 47% of those with net patient revenue below $250 million and 60% of those with net patient revenue between $250 million and $999.9 million.
- More than two-thirds of medium (69%) and large hospitals (67%) say their EDs are often or always overcrowded, compared to only 36% of small hospitals.
- Nearly equal percentages of hospitals (7%) and health systems (8%) report that their EDs are always overcrowded. Sixteen percent of large hospitals say their EDs are always overcrowded.
- Higher percentages of respondents from the Northeast (72%) and South (62%) report EDs that are often or always experiencing overcrowding, than respondents from the West (52%) and Midwest (37%).

WHAT DOES IT MEAN?

While there is a logic to the notion that larger organizations would have more patients and, therefore, more ED overcrowding—which we see here by various measures (hospital bed count, health system site count, organization net patient revenue)—one also might reasonably expect the larger organizations to be better staffed and more advanced in terms of handling such a well-known and long-standing challenge.

DATA SEGMENTATION TOOL
Click these icons to dig deeper
VIEW BY ED OVERCROWDING STATUS
VIEW BY SETTING
VIEW BY NUMBER OF BEDS
VIEW BY NUMBER OF SITES
VIEW BY NET PATIENT REVENUE
VIEW BY REGION
MAIN CHART AND TAKEAWAYS

FIGURE 1 *(continued)* | ED Overcrowding

Q | How often is your ED overcrowded?

Click these icons to dig deeper

BUYING POWER Who controls the money? Click on the icons to learn how they think

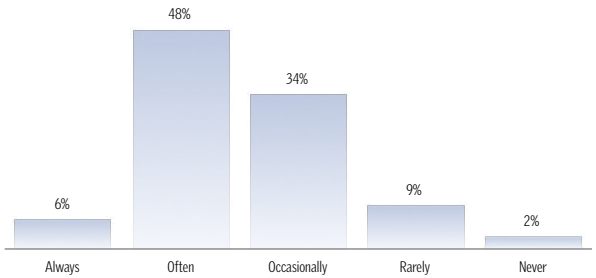
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

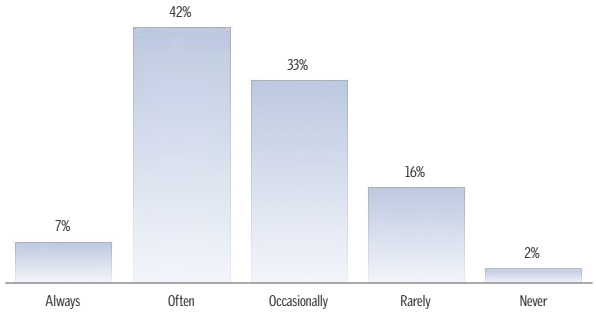
PRODUCTS/SERVICES

Clinical products



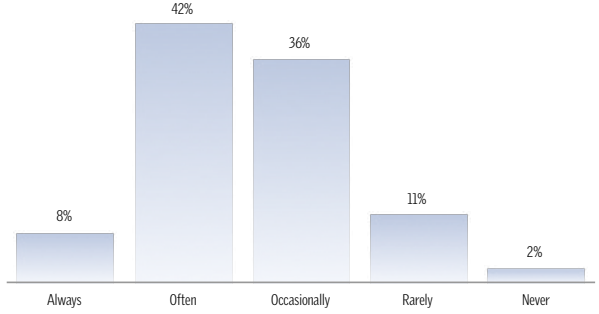
Base = 257

Financial services



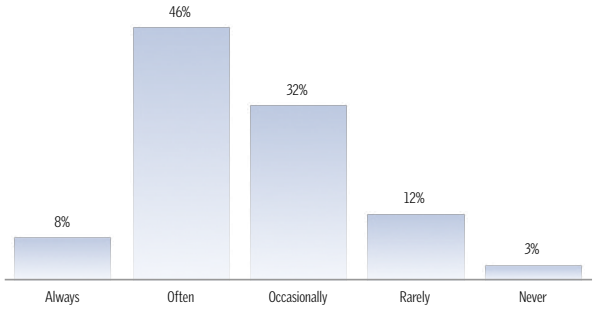
Base = 90

Executive search



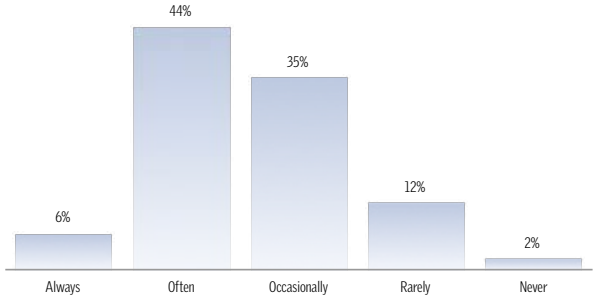
Base = 137

Consulting services



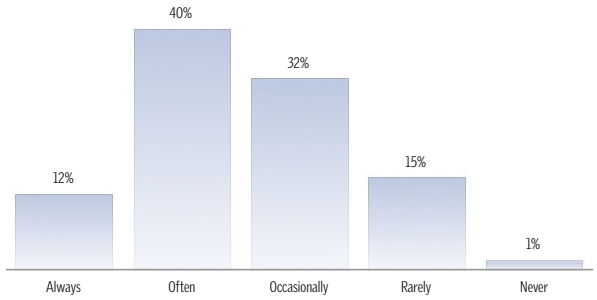
Base = 160

Outsourcing services



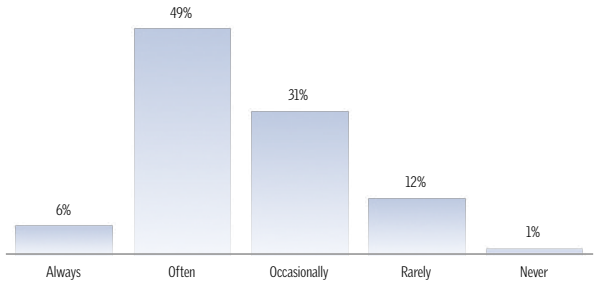
Base = 108

Legal services



Base = 73

Information technology

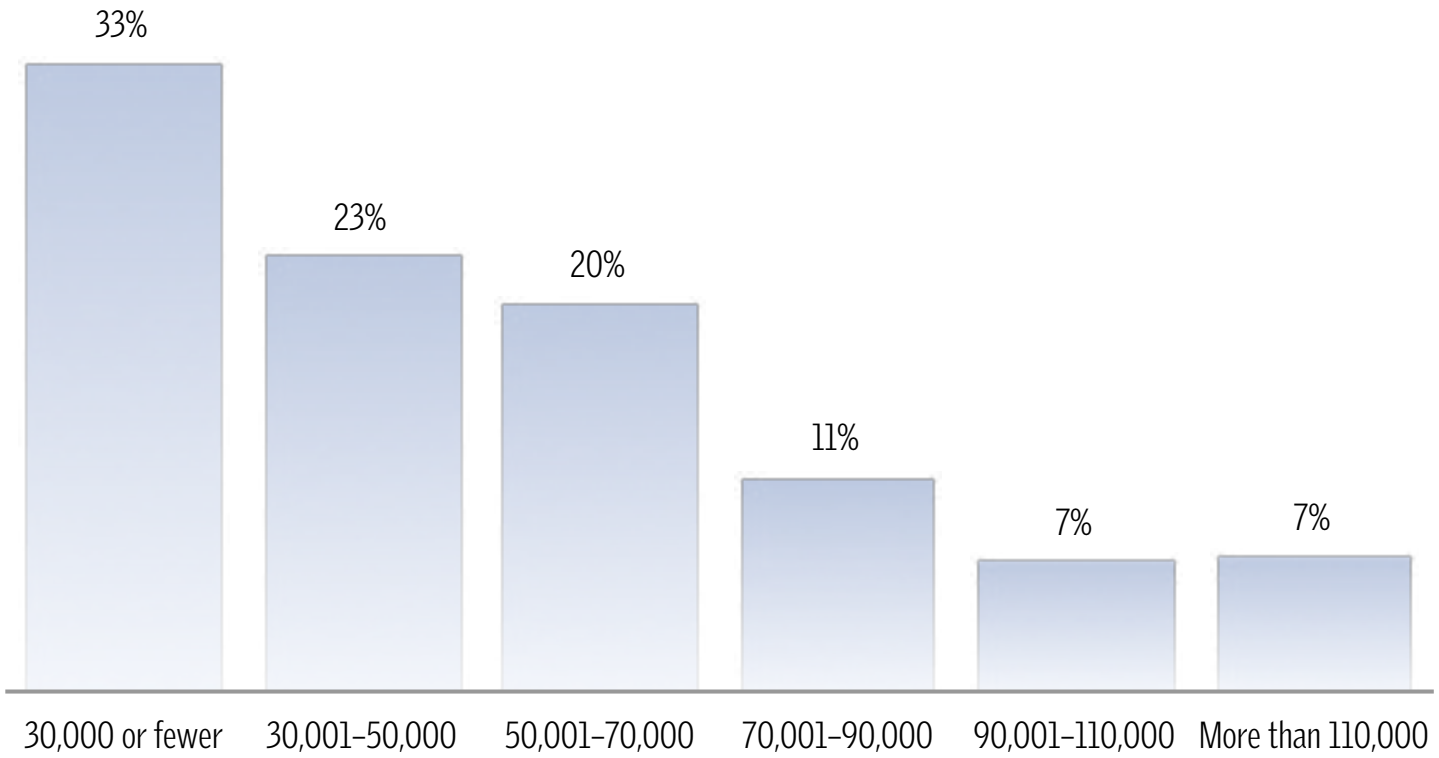


Base = 198

FIGURE 2 | Annual Visits to ED

Q | What is the approximate number of annual patient visits to your ED?
(If you are part of a multiunit health system, please report or estimate the annual visits for your individual ED.)

Total responses

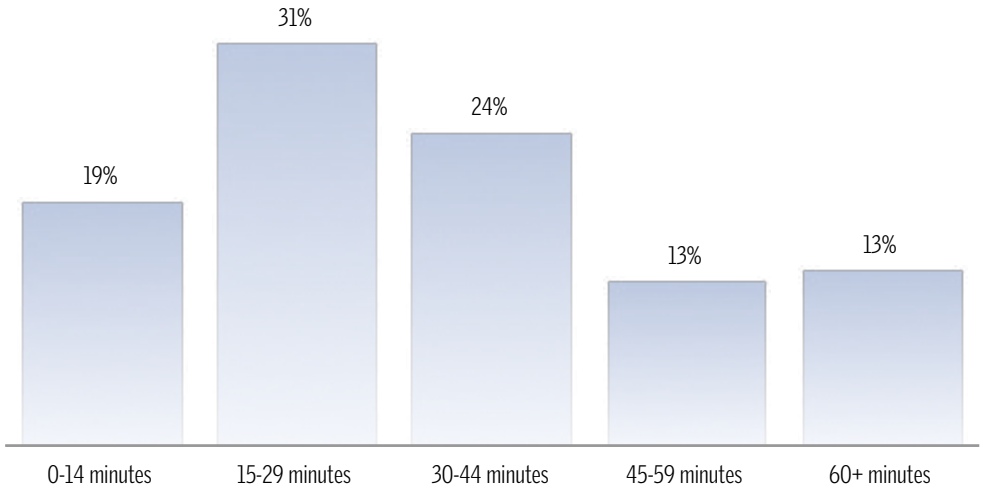


Base = 407

FIGURE 3 | Average ED Wait Time

Q | What is the current measure of the average time patients spend in your ED before they are seen by a healthcare professional?

Total responses



Base = 335
Mean = 36 minutes

TAKEAWAYS

- Overall, the average time patients spend in respondents' EDs before they are seen by a healthcare professional is 36 minutes.
- Wait times are, on average, shorter at hospitals (34 minutes) than at health systems (42 minutes).
- The largest organizations by net patient revenue have the longest wait times. Respondents from organizations with $1 billion or more of net patient revenue report an average time before being seen of 49 minutes, compared to only 30 minutes reported by those from organizations with less than $250 million in net patient revenue.
- Those who report that their EDs are always or often overcrowded report an average wait time of 46 minutes. Visitors to EDs that are characterized as occasionally, rarely, or never overcrowded are seen in an average of 23 minutes.

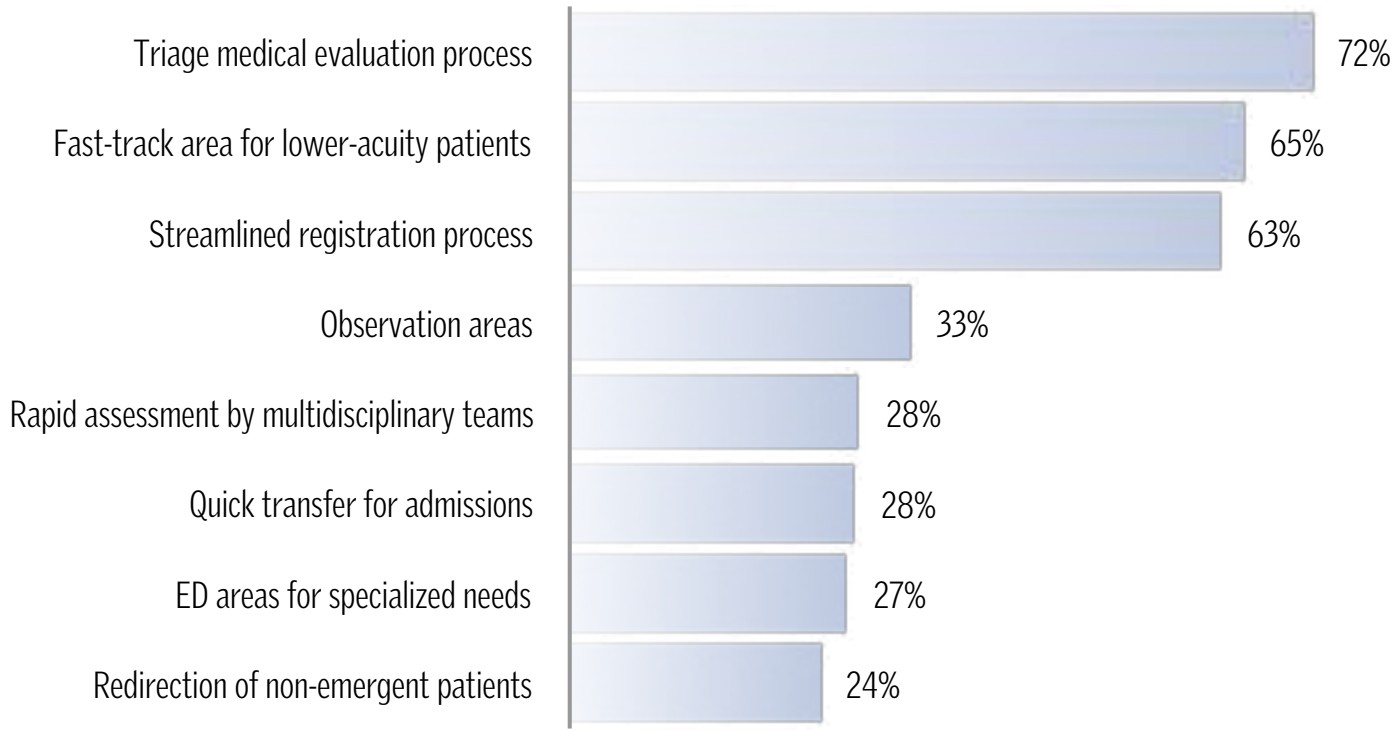
WHAT DOES IT MEAN?

The averages indicate that waits are longer at larger organizations. Report advisors tell us that long wait times are associated with higher patient morbidity, increased chances that a patient would be overlooked if the patient's condition worsens, an increased number of patients who leave without being seen, and lower patient satisfaction scores.

FIGURE 4 | ED Operations Techniques to Increase Efficiency

Q | Please identify the ED operations techniques you are using to increase your ED throughput efficiency.

Total responses

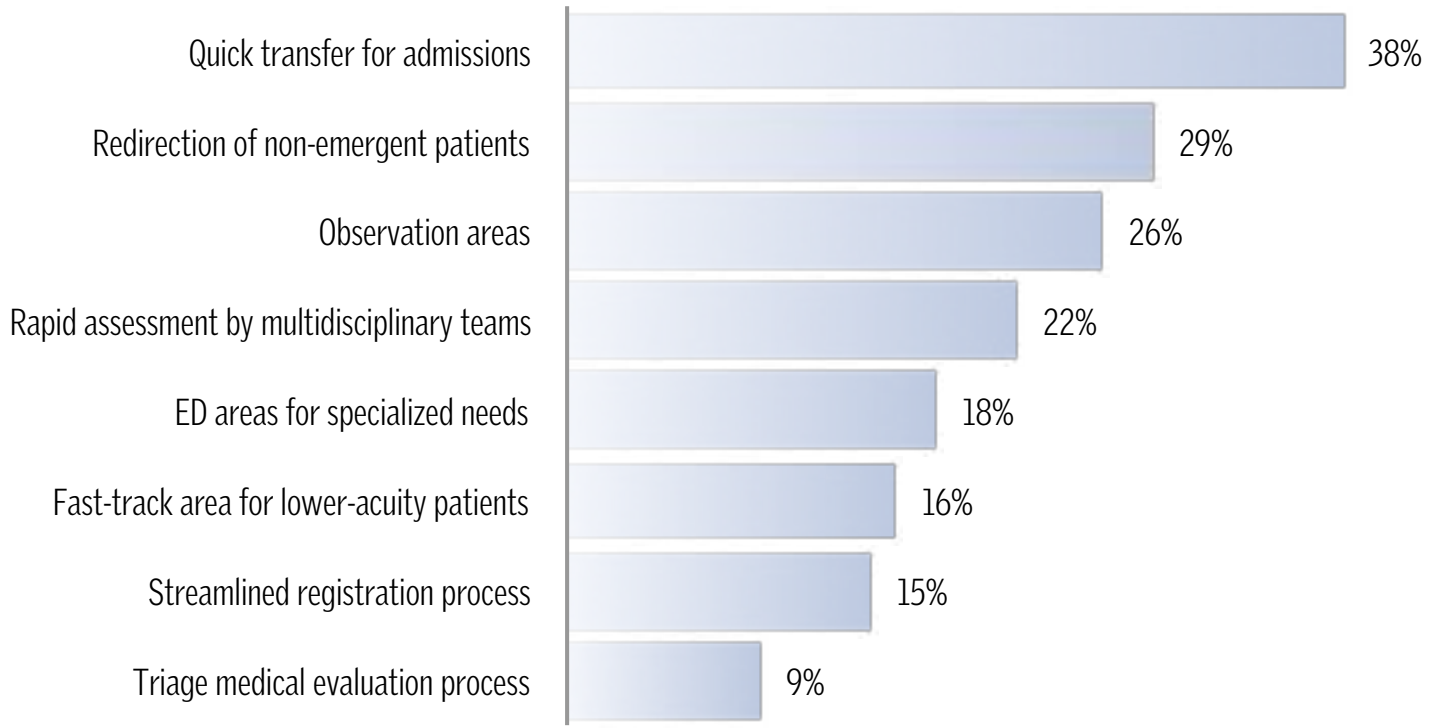


Base = 407, Multi-Response

FIGURE 5 | ED Operations Techniques to Increase Efficiency Next Three Years

Q | Please identify the ED operations techniques not currently developed that you expect to pursue over the next three years to improve your ED throughput efficiency.

Total responses

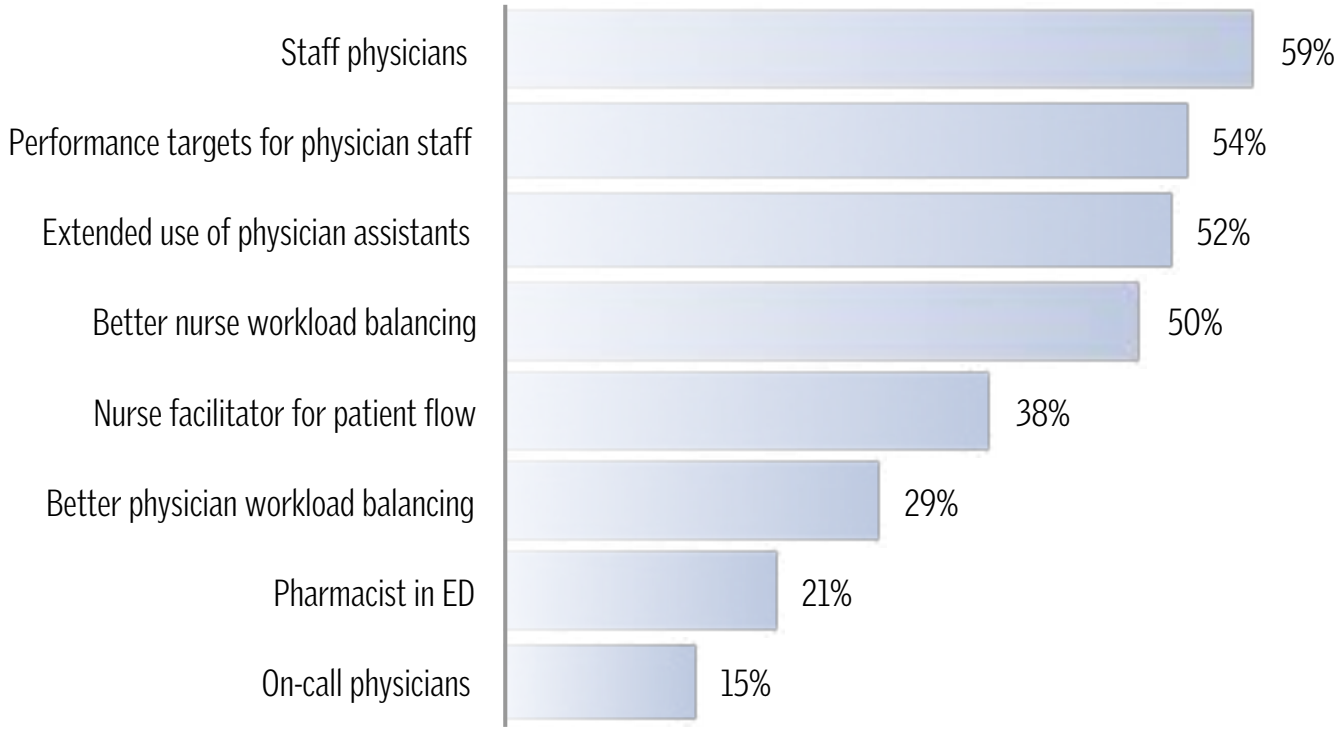


Base = 407, Multi-Response

FIGURE 6 | Most Effective Staffing Techniques to Improve ED Efficiency

Q | Please identify the most effective staffing and staff management techniques you are using to improve your ED throughput efficiency.

Total responses



Base = 407, Multi-Response

FIGURE 7 | Status of Urgent Care Centers

Q | Describe your organization's strategy regarding urgent care centers.

Total responses

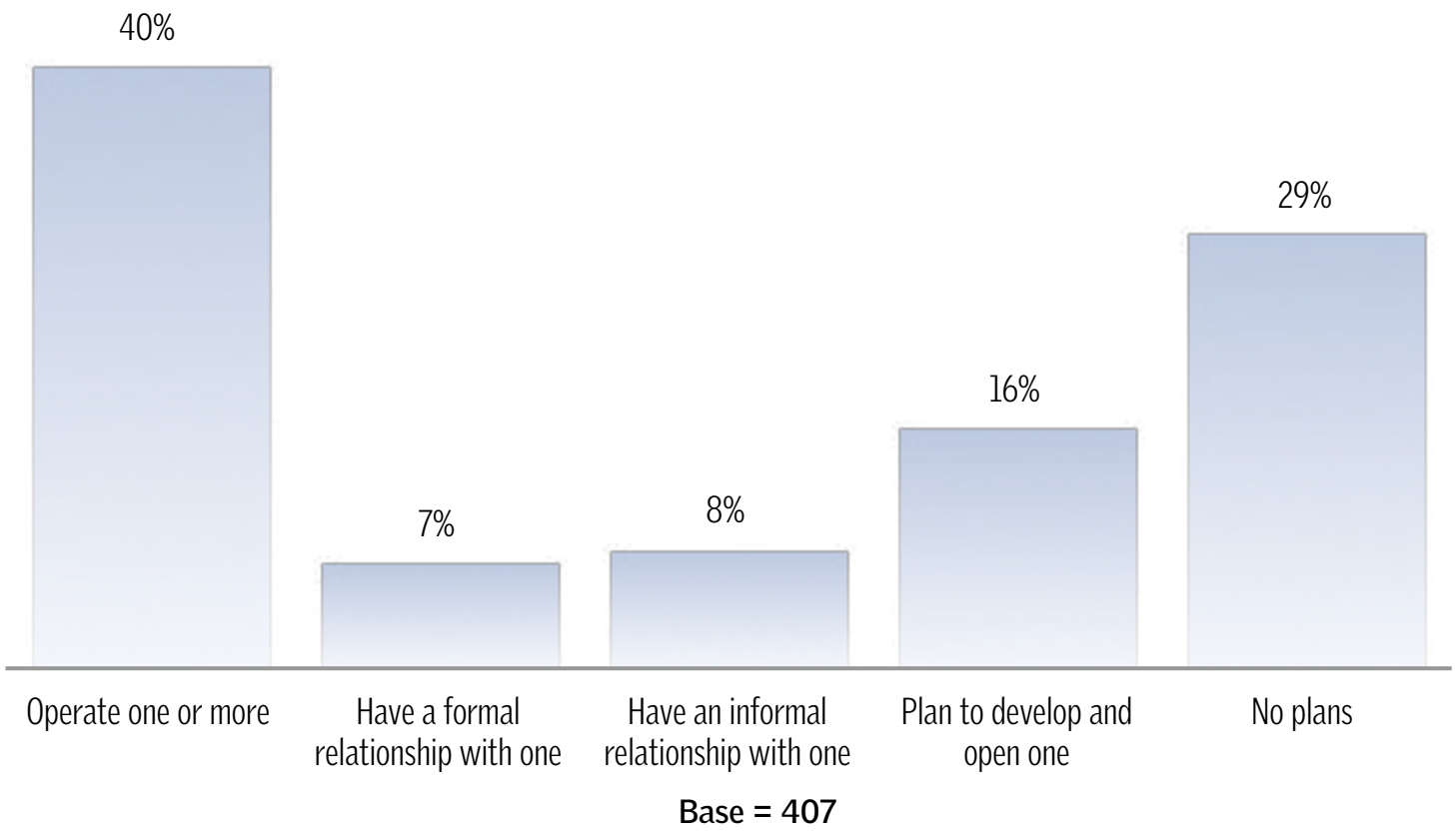
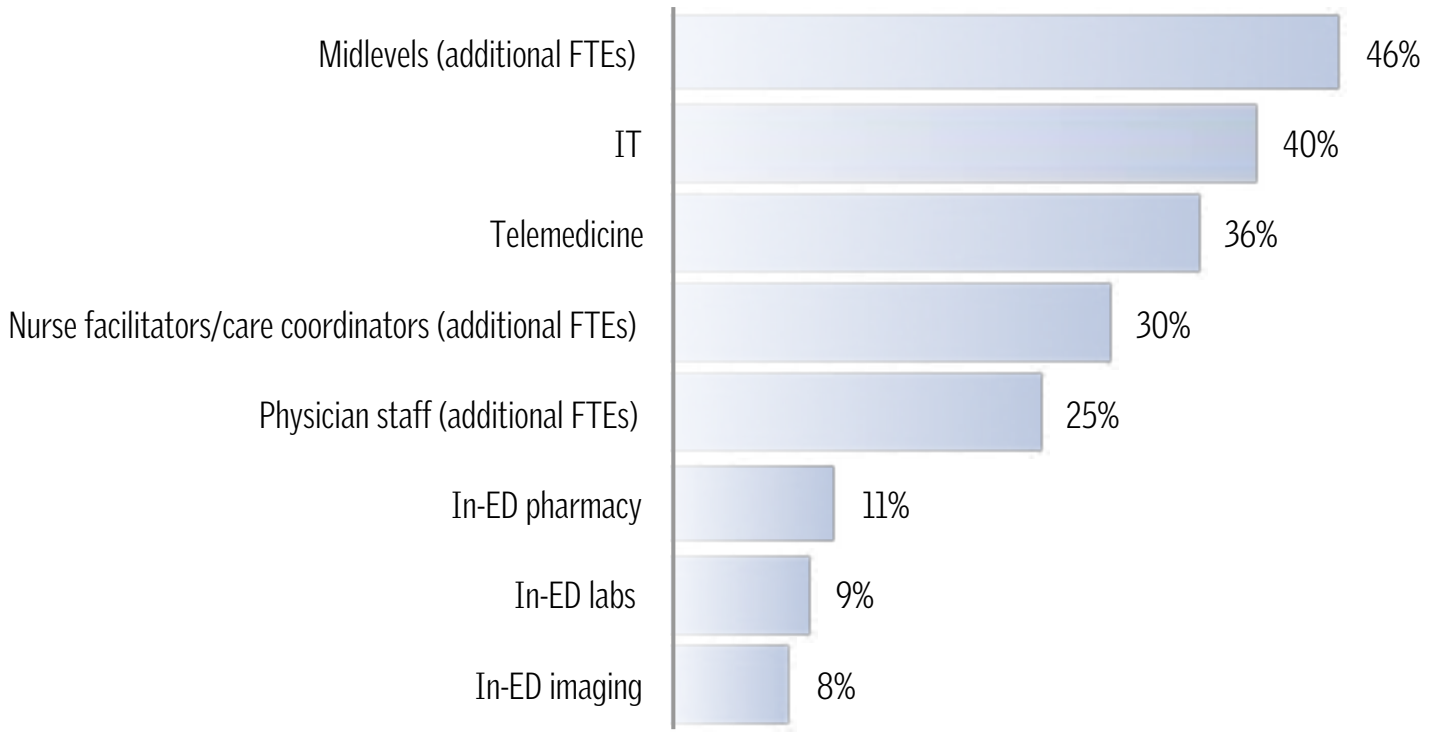


FIGURE 8 | ED Investments Next Three Years

Q | Which of the following will you invest in within the next three years in support of your ED?

Total responses

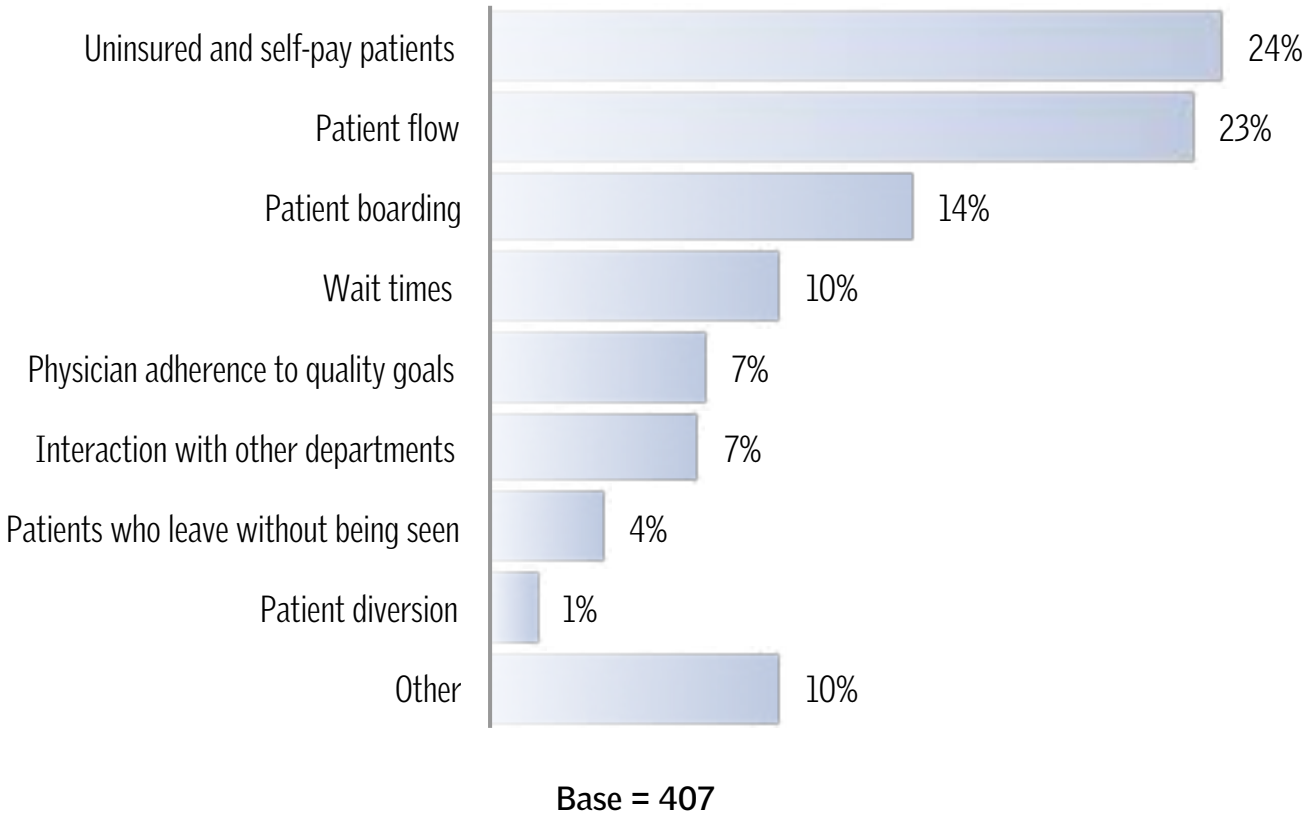


Base = 407, Multi-Response

FIGURE 9 | Greatest ED Challenge

Q | What is the greatest challenge regarding your ED?

Total responses



Base = 407

FIGURE 10 | ED Changes Next Three Years

Q | Are you preparing for the following to increase, stay the same, or decrease within the next three years?

Total responses

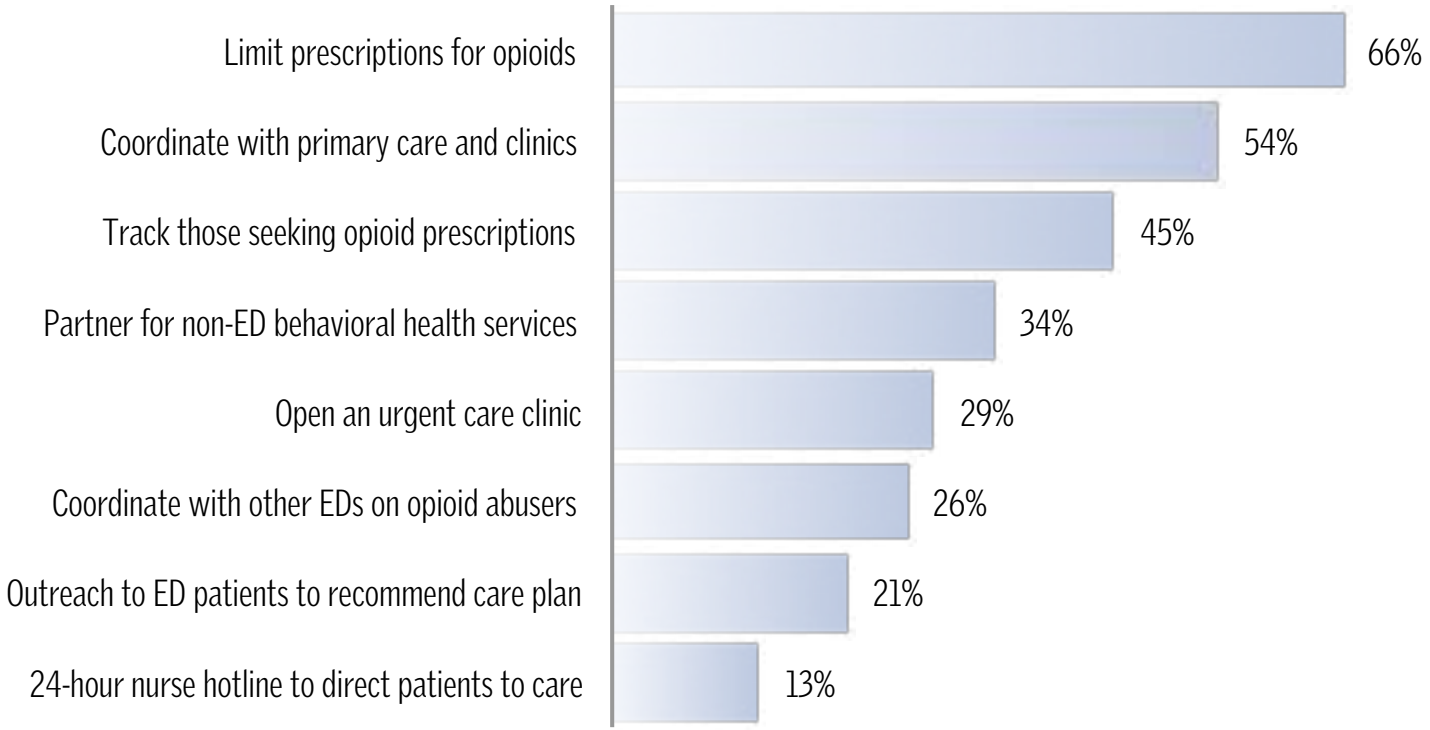
	Increase	Stay the same	Decrease
ED quality outcomes	79%	19%	2%
ED patient volume	65%	25%	10%
Insured patients not paying deductible/copay	53%	40%	7%
Uninsured/self-pay ED patients	41%	39%	19%
Percentage of non-emergent patients	41%	37%	23%
Volume of hospital admissions from the ED	37%	43%	19%
ED operating margin	10%	31%	59%
ED reimbursement rates	6%	24%	70%

Base = 407

FIGURE 11 | Tactics to Minimize Avoidable ED Visits

Q | Which tactics do you use to minimize avoidable visits to your ED?

Total responses



Base = 407, Multi-Response

FIGURE 12 | ED Status With Care Continuum Providers

Q | What is the status of your ED's relationship with respect to the following care continuum providers or services?

Total responses

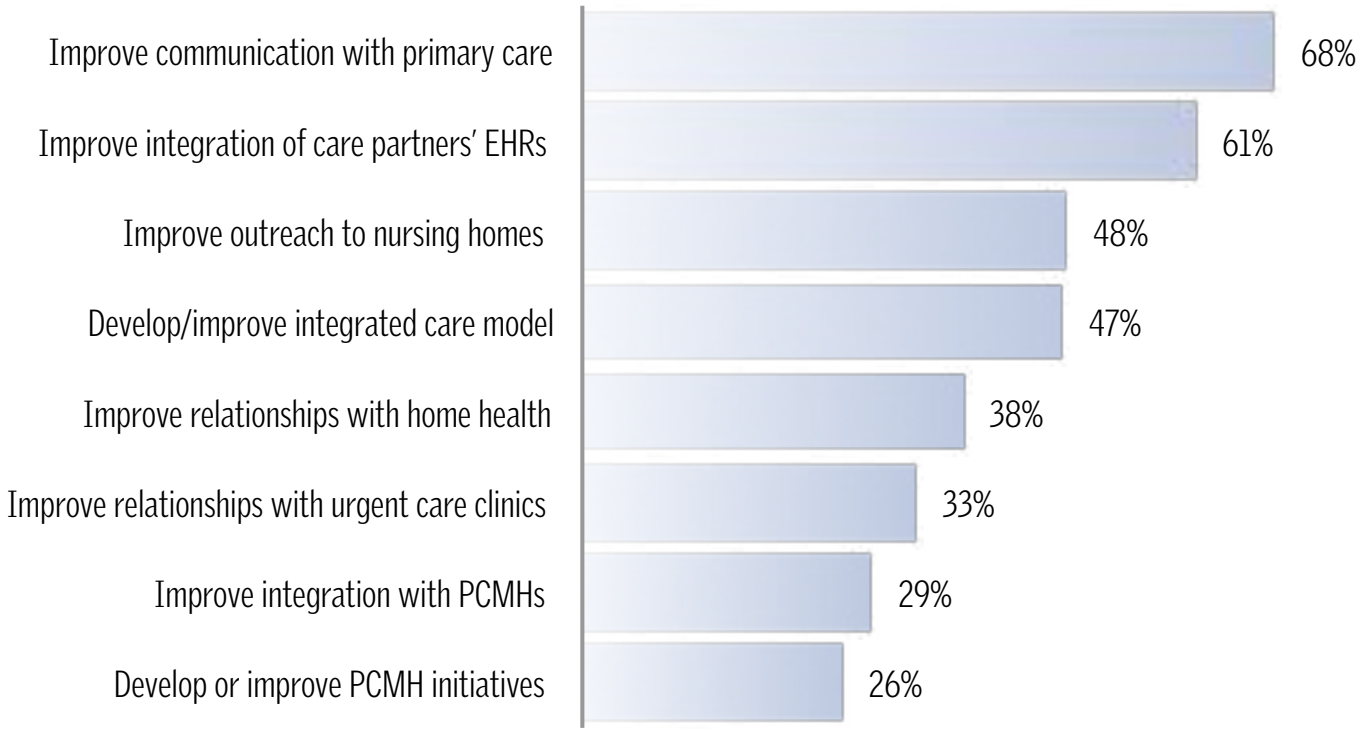
	In place, strong	In place, not strong	Not in place, but developing	Not pursuing
Primary care physicians	55%	39%	4%	2%
Social services	44%	43%	8%	5%
Home health	43%	36%	10%	11%
Nursing home facilities	38%	44%	8%	10%
Rehabilitation facilities	34%	43%	8%	15%
Community-based clinics/FQHCs	33%	40%	17%	11%
Mental health services	29%	52%	13%	7%
Other postacute care facilities	15%	43%	17%	25%

Base = 407

FIGURE 13 | Improving Relationships With Care Continuum Providers

Q | What steps are you taking or do you expect to take next to improve your ED's relationships along the continuum of care?

Total responses

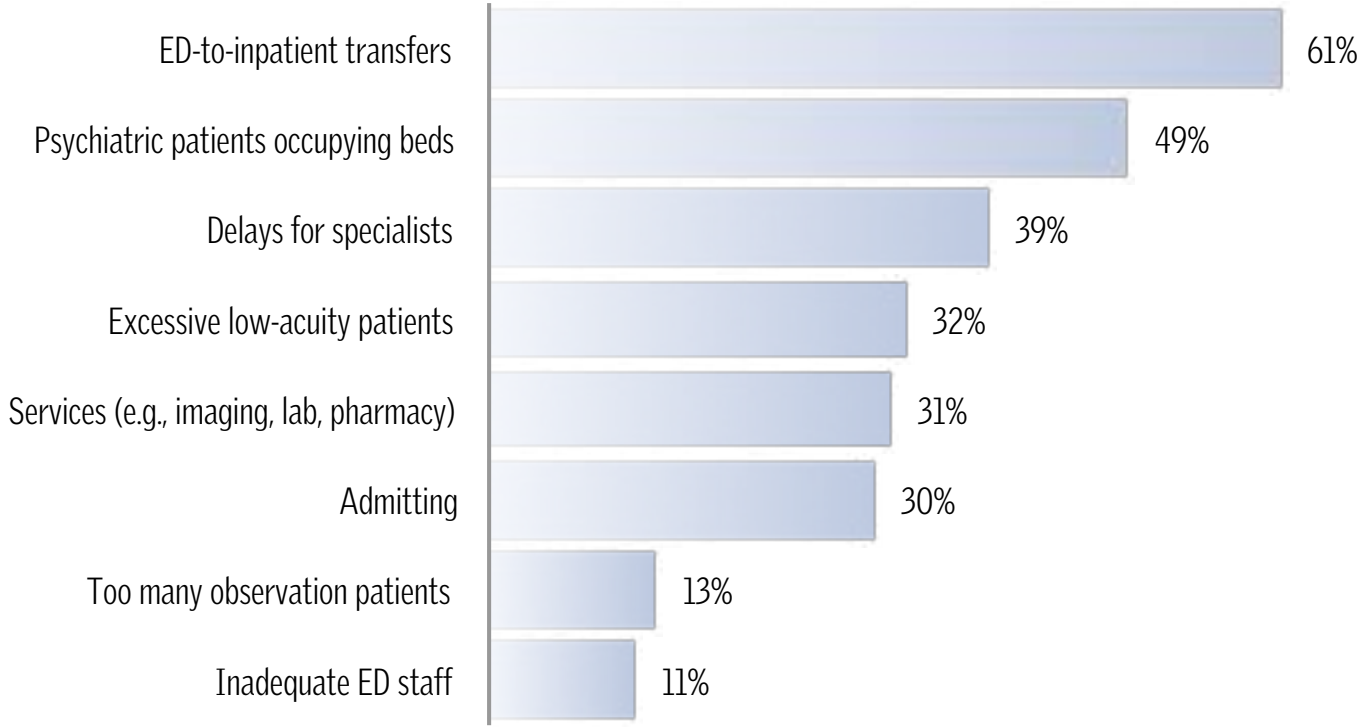


Base = 407, Multi-Response

FIGURE 14 | Biggest Bottleneck Problems for ED Flow

Q | Please select the three factors that present the biggest bottleneck problems for ED flow.

Total responses



Base = 407, Multi-Response

Access.
Insight.
Analysis.

Council

The nation's most exclusive
healthcare intelligence community

Be a voice
Gain insight from your peers
Shape the direction of the industry

Join today at *www.healthleadersmediacouncil.com*