CASE STUDY

Rebuilding EMS Trust and Front-End Patient Flow

A DOWNTOWN HOUSTON HOSPITAL

ELITE HOSPITAL PARTNERS

This urban ED served a substantial homeless and psychiatric population and had become associated with those services among EMS crews. Long waits, poor flow, and an unstable physician core weakened confidence in its broader capabilities. EHP rebuilt staffing, front-end care, and the pathways through which patients reached the hospital.

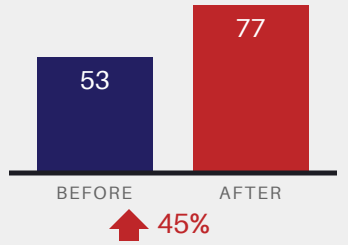
MOVE PATIENTS PAST THE TRIAGE BOTTLENECK

EHP introduced true pull-to-full: appropriate available rooms in the back were used rather than leaving patients waiting to finish traditional triage. Quick triage established acuity and placement needs; the remaining intake work followed the patient into care. Direct bedding was paired with immediate physician engagement and rapid medical screening so that moving a patient changed the course of care, not just the location of waiting.

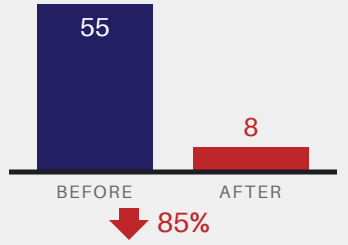
BUILD A FUNCTIONING FRONT END DURING SATURATION

Diversion had been overly utilized during busy periods. EHP instituted a no-diversion approach to routine saturation, keeping the hospital available to EMS and incoming patients. When the back filled, an active front-end pathway and split-flow / fast-track model supported evaluation, treatment, and disposition. That pathway required assigned staff, supplies, and clear responsibility for the next action. Testing and treatment moved in parallel where appropriate. Daily monitoring and physician scorecards reinforced continued movement through disposition.

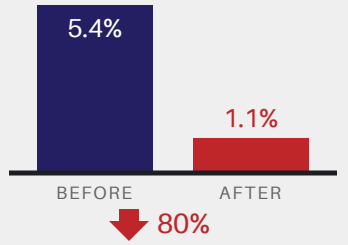
Daily ED visits



Door to physician (min)



Left without being seen



CHANGE THE EXPERIENCE FOR EMS

Providers met crews on arrival, with a wall-time goal of less than 10 minutes. Physicians and nurses were expected to accept the handoff respectfully and avoid challenging crews about destination choices. EHP purchased a massage chair and worked with the hospital to improve lounge food and drinks. Those investments supported a broader change in responsiveness and professional behavior.

PROVIDER IN TRIAGE

EHP does not use a provider-in-triage (PIT) model to improve metrics. Although there are good PIT models, for the most part PIT is a time stamp. EHP fixes the process, and the metrics follow.

Sustaining the process and measuring the results

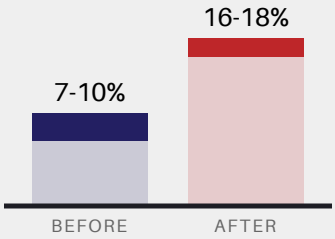
BUILD THE CREW AROUND THE PROCESS

EHP replaced the fragmented staffing approach with a dedicated full-time physician crew and a dedicated medical director. Expectations included prompt evaluation, active patient movement, respectful relationships with nurses, and participation in rebuilding the hospital. The medical director updated onboarding as consultation and overnight admission processes changed.

MAKE THE WORKFLOW A HOSPITAL RESPONSIBILITY

A hospital throughput committee brought attention to barriers outside the ED. Leadership also collected and escalated specific examples of admission delays and difficult hospitalist interactions. Process review followed laboratory collection and results, imaging completion, reassessment, and inpatient placement. Departments needed clear ownership of each handoff. Improving arrival access increased the importance of a dependable next step after evaluation.

Encounters resulting in admission



EMS traffic

+30%

FROM BASELINE

Operating model

Rooms available in the back

True pull-to-full: bypass the triage queue and move patients into appropriate available treatment space.

Initial acuity assessment

Quick triage: obtain the essentials needed for safe placement; complete remaining steps around care.

Back of the ED saturated

Continue receiving patients without diversion for routine saturation; activate front-end evaluation, treatment, and disposition.

CREATE RELIABLE TRANSFER ACCESS

Working with the CEO, EHP supported outreach and service-line development. Agreements with surrounding freestanding EDs established acceptance pathways for appropriate transfers and admissions. With no transfer line or center in place, EHP led creation of a transfer line and an ED-to-ED process so outside facilities had a usable route into the hospital.

CONNECT DOCUMENTATION WITH CLINICAL WORK

Documentation coaching and customized AI scribe support helped physicians reflect their medical decision-making. In a challenging payer environment, greater volume and admission capture created opportunities for hospital facility and inpatient revenue. No dollar estimate is assigned to that impact.

REPORTED OUTCOMES

MEASURE	BEFORE	AFTER	CHANGE
Average daily ED visits	53	**77**	**+45%**
Door-to-physician time	55 min	**8 min**	**−85%**
Left without being seen	5.4%	**1.1%**	**−80%**
ED encounters resulting in admission	7-10%	**16-18%**	—
EMS traffic	Baseline	**+30%**	**+30%**

Before figures reflect the department prior to the changes described. After figures reflect a later period under EHP management. Individual measures improved at different points. The less-than-10-minute EMS wall time was a process goal, not a measured result supplied for this comparison. Admission figures are shares of ED encounters. Results are descriptive before-and-after observations.

