CASE STUDY

Rebuilding Access through True Pull-to-Full

A NORTH TEXAS COMMUNITY HOSPITAL

ELITE HOSPITAL PARTNERS

A low-volume community emergency department had lost the confidence of patients and EMS. Daily visits averaged 22, physician access took 55 minutes, and the combined LWBS/AMA measure was 4.9%. EHP rebuilt the physician team and redesigned how patients entered, moved through, and left the department.

MAKE AVAILABLE ROOMS AVAILABLE TO PATIENTS

The core change was true pull-to-full. When appropriate rooms were available in the back, patients bypassed the traditional triage queue and moved into treatment space. Quick triage established the essentials for safe placement. Remaining triage and registration tasks were completed around care rather than becoming prerequisites to entering a room. This required physicians and nurses to share responsibility for getting patients into care.

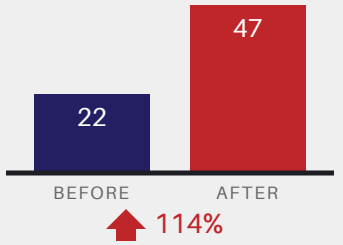
KEEP CARE MOVING WHEN THE BACK IS FULL

Diversion had been overused when the department was busy. EHP instituted a no-diversion approach to routine saturation: continue receiving patients and activate the front-end care process. The front-end pathway needed an assigned team, necessary supplies, and a place to evaluate and treat patients. Workup and treatment proceeded while back rooms were occupied. Remaining triage tasks, testing, and care moved in parallel where appropriate; the front end could not function as another holding queue.

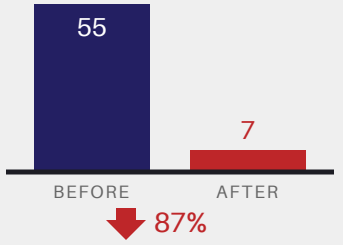
REPLACE THE STAFFING MODEL

EHP retained two existing physicians and recruited the rest as a new full-time crew. Selection emphasized urgency, teamwork, patient experience, and willingness to help operate the department. A dedicated medical director reinforced those expectations. Staffing decisions also incorporated candid feedback from EMS about individual physicians and their experience in the department.

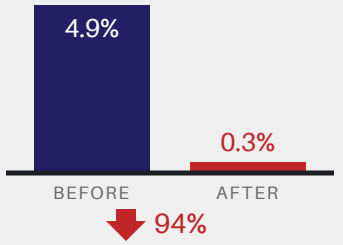
Daily ED visits



Door to physician (min)



Combined LWBS / AMA



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

REINFORCE EACH HANDOFF

Leadership checked room use, physician engagement, and timely orders and dispositions. Review followed specimen collection, diagnostic completion, reassessment, and departure. Each handoff needed a next action and owner, reinforced through physician accountability and nursing communication.

REBUILD EMS AND COMMUNITY CONFIDENCE

EHP set an EMS wall-time goal under 10 minutes, with direct bedding and providers meeting crews for handoff. Leadership listened to EMS concerns and used feedback in staffing decisions. Reliable acceptance and prompt handoffs supported renewed confidence. Marketing, community outreach, and weekly medical segments on local television accompanied the operational changes.

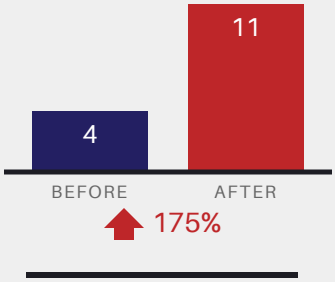
FOLLOW DELAYS BEYOND THE ED

EHP developed an interdepartmental throughput agenda, started manual hospitalist metrics tracking, and prepared a hospitalist practice guide. Leadership addressed consult handoffs and delayed inpatient evaluations. Work with imaging leadership also targeted contrast-imaging rules that created avoidable waits; the record documents policy development rather than a confirmed go-live.

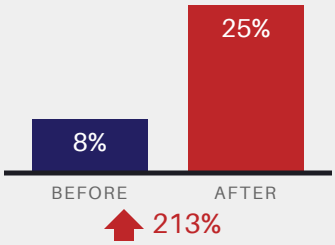
SUPPORT THE PHYSICIANS EXPECTED TO CHANGE

Documentation feedback addressed the 2023 emergency medicine guidelines. EHP also worked with Doc Assistant AI to customize medical decision-making documentation. The approach paired clear operating expectations with practical support for the physicians carrying them out.

Daily EMS arrivals



Encounters resulting in admission



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.

REPORTED OUTCOMES

MEASURE	BEFORE	AFTER	CHANGE
Average daily ED visits	22	**47**	**+114%**
Door-to-physician time	55 min	**7 min**	**−87%**
Combined LWBS / AMA	4.9%	**0.3%**	**−94%**
Average daily EMS arrivals	4	**11**	**+175%**
ED encounters resulting in admission	8%	**25%**	**+213%**

Historical before-and-after comparison during EHP management. LWBS (left without being seen) and AMA (against medical advice) are reported as a combined measure. EMS wall time under 10 minutes was a goal, not a measured result supplied here. Changes are descriptive.

