CASE STUDY

Rebuilding a High-Volume Emergency Department Around Shared Responsibility

A HIGH-VOLUME OKLAHOMA HOSPITAL

ELITE HOSPITAL PARTNERS

This emergency department is now the busiest in the Elite Hospital Partners group and the site with its strongest operational metrics. It averages 183 patients per day, door-to-doctor time is eight minutes, and LWBS averages 0.8%. The turnaround began in 2018 under the physician leadership that now leads EHP. EHP has continued the same management and operating approach since.

THE DEPARTMENT BEFORE THE TURNAROUND

The prior contractor was a large national, private-equity-backed emergency medicine company with numerous Oklahoma contracts. Its physicians rotated among hospitals, and only a couple considered this department their primary site. Many avoided working there because throughput was so poor.

Patients could wait hours before seeing a physician, with little attention to whether they had been screened, evaluated, or started on care. When the department was busy, physicians sometimes told nurses to stop bringing patients into the back. The culture accepted physicians stopping new patient evaluations two to three hours before the end of a shift. Two physicians started 12-hour shifts at 7 a.m. and two at 7 p.m., with no staggered starts and no overlap. Patients were assigned through a rotating tick system. Physicians took turns, and no one was responsible for the patients still waiting or for the department's total workload.

The medical director's office showed how little operational leadership was present. When the incoming physician leader asked where it was, staff did not know. Maintenance had to let the team in because no one had a key. The tags were still on the furniture.

Patients per day

183

Current average

Door to doctor

8 min

Since the start of the turnaround

Left without being seen

0.8%

First month and current average

"Dr. Darrigan and his management have had a tremendous impact on the daily delivery of healthcare to patients. The physicians are incentivized to deliver quality patient care and feel like true members of the group, which has had the biggest impact."

Brent Smith
Chief Executive Officer

PREPARATION BEFORE LAUNCH

The incoming physician leadership spent months with the ED nurse manager before the new model went live. They redesigned patient flow, set physician expectations, aligned nursing and physician responsibilities, and prepared the team to carry out the changes from the first day. LWBS reached 0.8% in the first month. EHP's commitment to measurable results in the first month of new contracts is based on this experience.

HOW PATIENTS ENTER THE DEPARTMENT

When appropriate treatment space was available in the back, patients bypassed the triage queue and moved directly into it. Quick triage collected the information needed for acuity and placement. The remaining triage and registration steps happened around care. Physicians and nurses became jointly responsible for using the department's available capacity, and physicians could no longer tell nurses to stop bringing patients back.

When the main rooms were full, physicians and APCs began care at the front end through pre-evaluation and internal waiting, and the hospital added nursing support for the process. Evaluation, orders, testing, treatment, reassessment, and discharge moved forward while patients waited for a room. Diversion for routine saturation ended.

NO PROVIDER-IN-TRIAGE SHIFT

There is no separate physician-in-triage or APC-in-triage (PIT) shift at this hospital or at any EHP site. The existing physicians and APCs run the front-end process as part of their clinical work. Although there are good PIT models, for the most part PIT is a time stamp. EHP fixes the process, and the metrics follow.

Operating model

Physician coverage
BEFORE Rotating physicians; only a couple considered it their primary site
NOW Full-time physicians and APCs; no locums

Shift schedule
BEFORE Two physicians at 7 a.m. and two at 7 p.m.; no overlap
NOW Staggered starts with overlap

Patient assignment
BEFORE Rotating tick system
NOW Open patient pickup in a shared work area

Arrival
BEFORE Full triage and registration before a room
NOW Pull-to-full with quick triage

Back of the ED full
BEFORE Patients waited; physicians told nurses to stop bringing patients back
NOW Pre-evaluation and internal waiting

Busy periods
BEFORE Diversion overused
NOW No diversion for routine saturation

Admissions
BEFORE Prolonged hospitalist evaluation; frequent pushback
NOW Faster, simpler process with administrative backing

Compensation
NOW Percentage of RVUs billed; productivity unblinded

Leadership
BEFORE Medical director's office unused
NOW Active medical director; throughput committee

HOW THE PHYSICIANS WORK TOGETHER

The tick system was eliminated. Physicians moved to open patient pickup in a shared working area, where they talk directly about flow, workload, and the department's needs. Shifts were reorganized with staggered starts and overlap.

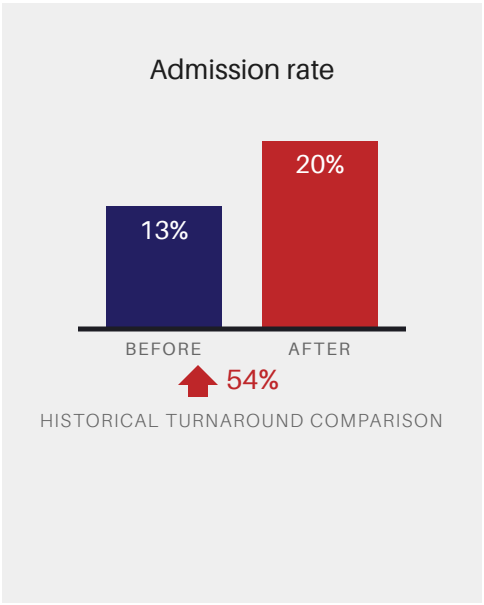
Physician compensation is based on a percentage of RVUs billed, and individual productivity is unblinded. Every physician can see how the work is distributed across the group. When someone is not carrying their share, the physicians discuss it directly and work through the reasons, and persistently lower productivity results in lower compensation. Over time, financial consequence and peer accountability make the practice less attractive to physicians unwilling to contribute. The practice favors those willing to work, collaborate, and carry their share. Productivity is measured on seeing patients and completing their care, under the same expectations for appropriate clinical decisions that apply to the whole group.

Leadership also coached and developed a newly selected medical director, a former chief resident. That role took on the working relationships with nursing and administration and day-to-day provider accountability.

WORK OUTSIDE THE ED

A throughput committee brought in the departments that affect ED performance, including laboratory, imaging, admission coordination, bed assignment, transport, and discharge. Departments were held accountable for turnaround times. The committee identified where work stopped and who was responsible for moving it forward.

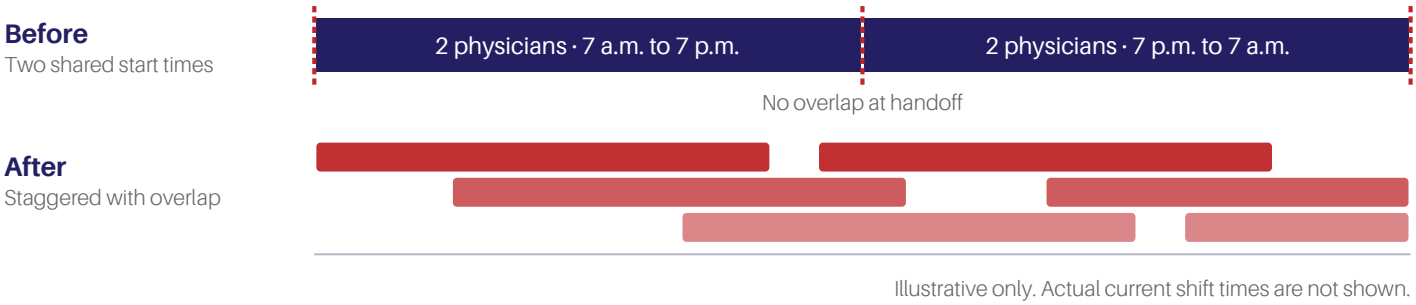
Before the change, hospitalists could take a long time to come to the ED and evaluate a patient before agreeing to admit, and admissions were frequently challenged. ED leadership told administration that it would take a firm position on inappropriate refusals and would need the hospital's support. Administration backed that approach. There were direct disagreements during implementation, but a faster, simpler admission process with clear expectations was established quickly. Admission capture increased, and the hospital benefited financially. In the historical turnaround comparison, admissions rose from 13% to 20% of ED encounters.



THE DEPARTMENT TODAY

The department is staffed by full-time physicians and APCs with no locums coverage. The group is heavily involved in the hospital's emergency medicine residency, and graduating residents want to stay on as attending physicians. Volume has grown to an average of 183 patients per day. Door-to-doctor time remains eight minutes, and LWBS averages 0.8%.

PHYSICIAN SCHEDULE



Illustrative only. Actual current shift times are not shown.

RESULTS

MEASURE	RESULT	BASIS
Door-to-doctor time	**8 minutes**	From the start of the turnaround; current
Left without being seen	**0.8%**	First month; current average
Average daily volume	**183**	Current; baseline not reported
Admission capture	**13% to 20%**	Historical turnaround comparison; not the current rate
EMS wall time	**Under 10 minutes**	Operating goal, not a measured result

