CASE STUDIES

Results Across Four Emergency Departments

ELITE HOSPITAL PARTNERS

Elite Hospital Partners manages emergency departments at community, urban, and high-volume hospitals. The four departments below started from different conditions, and each made its own changes on top of the same operating model. Each site's figures are its own before-and-after comparison and should be read on their own.

A SOUTHEAST TEXAS COMMUNITY HOSPITAL

Active medical direction: protecting direct bedding, encounter-level review, and follow-up on diagnostic and inpatient movement barriers.

Daily ED visits	55 → 70
Door to physician	70 → 6 min
LWBS	7% → 0.8%

A DOWNTOWN HOUSTON HOSPITAL

Rebuilding EMS confidence and a dedicated physician team, and creating a transfer pathway where none existed.

Daily ED visits	53 → 77
Door to physician	55 → 8 min
LWBS	5.4% → 1.1%

A NORTH TEXAS COMMUNITY HOSPITAL

A rebuilt physician team informed by EMS feedback, faster access, and renewed community confidence.

Daily ED visits	22 → 47
Door to physician	55 → 7 min
LWBS / AMA combined	4.9% → 0.3%

A HIGH-VOLUME OKLAHOMA HOSPITAL

Shared responsibility: open patient pickup, transparent RVU-linked compensation, and administrative backing for the admission process.

Patients per day	183 current
Door to doctor	8 min
LWBS	0.8% current

> *"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*

WHAT ALL FOUR SITES SHARE

TRUE PULL-TO-FULL

When appropriate treatment space is available in the back, patients move directly into it instead of waiting to finish a traditional triage process. Physicians and nurses are responsible for evaluating the patient, placing orders, and advancing treatment once the patient is in the room.

A FRONT END WHEN THE BACK IS FULL

When main ED rooms are occupied, existing physicians and APCs begin evaluations and workups through pre-evaluation, internal waiting, and split flow where it applies. Nursing support allows testing, treatment, reassessment, and discharge to move forward.

NO DIVERSION FOR ROUTINE SATURATION

Diversion had been overused at these sites when the department was busy. Continuing to receive patients depends on functioning arrival processes, physician engagement, nursing coordination, and the front-end pathway.

ACTIVE MEDICAL DIRECTION

Medical directors take part in how the ED functions day to day. They identify delays, address physician behavior, work with nursing, and follow unresolved hospital barriers until someone acts on them.

QUICK TRIAGE

Quick triage establishes the essential acuity and placement information. Remaining triage, intake, and registration work happens around care instead of delaying entry into treatment space.

NO PIT SHIFT

No EHP site uses a separate physician-in-triage or APC-in-triage (PIT) shift. Although there are good PIT models, for the most part PIT is a time stamp. EHP fixes the process, and the metrics follow.

EMS HANDOFFS

Direct bedding when space is available, provider engagement at handoff, a wall-time goal under ten minutes, respectful acceptance of the crew's report, and destination concerns handled through leadership.

RESULTS BY SITE

A Southeast Texas community hospital

MEASURE	BEFORE	AFTER
Average daily ED visits	55	**70**
Door-to-physician time	70 min	**6 min**
Left without being seen	7%	**0.8%**
Left against medical advice	3%	**0.2%**
ED encounters resulting in admission	13%	**20%**

LWBS and AMA are separate measures.

A North Texas community hospital

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

LWBS and AMA are reported as a combined measure.

A downtown Houston hospital

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

Admission and EMS figures are approximate.

A high-volume Oklahoma hospital

MEASURE	RESULT	BASIS
Door-to-doctor time	**8 min**	Since the start of the turnaround
Left without being seen	**0.8%**	First month; current average
Average daily volume	**183**	Current
Admission capture	**13% to 20%**	Historical turnaround comparison

Pre-turnaround baselines are not reported.

Each site was measured differently and over different periods, and individual measures improved at different points. Before figures reflect each department prior to the changes described; after figures reflect a later period under EHP management. The EMS wall time under ten minutes is an operating goal, not a measured result.

