To: Local Government Elected Official
From: Anannya Dey
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Statement of Issue: What programs/regulations should hospitals implement to reduce emergency room wait time for patients and ensure timely access to care?

Background: Now more than ever, hospitals are reporting overcrowding in their emergency rooms, causing patients waiting hours to be seen by a provider. Prolonged ER wait time is associated with increased morbidity, mortality, decreased quality of care and low patient satisfaction. The recommended maximum wait time for ER is 15 minutes. But, nationally only 40% of patients in the ER are seen within 15 minutes of arrival and over 1% of patients leave the ER without being treated due to the long wait time[1]. Compared to previous years, ER wait times have spiked due to lack of primary care physicians. From 2003 through 2009, the mean wait time in U.S. emergency departments (EDs) increased 25%, from 46.5 minutes to 58.1 minutes.[2] Patients have no option but to seek non-emergency care in ERs or urgent cares. Despite its benefits, due to the EMTALA, the ER is essentially the only place where providers are mandated to provide care. This increases the wait time for all patients and leads to overcrowding. Without any new policies/interventions taking place, this issue might potentially become worse over time.

Landscaping: Experience of the ED staff such as the triage nurses and resources of the hospital can increase ER wait time. Timeliness and efficiency are two of the six domains of healthcare quality as defined by the Institute of medicine.[3] But the healthcare system in the US is very disorganized. The triage system currently in place in the ER lacks standardization. If triage nurses are not properly trained in prioritizing patients, this will impact workflow for the rest of the ER staff. Proper training of nurses and correct triage will reduce the wait time for patients and increase quality of service.

Most ED do not have enough beds/rooms for patients leading them to practice what is known as “boarding”. Boarding is defined as the practice of holding patients in the ED after they have been admitted to the hospital because no inpatient beds are available.[4] More than 40% of the staff time is then spent caring for patients who have already been admitted to the ED but are waiting for a bed.[4] Hospitals reach maximum capacity and all the patients have to wait and therefore new patients can not be admitted. Limited hospital resources do not allow the staff to work as efficiently as they could, increasing the wait time.

Most cases in the ER are not emergent, potentially increasing the time for patients with worser conditions. Many people do not have a regular primary care provider so the ER is their first and last resource. Most studies find that at least 30% of all ED visits in the US are non-urgent.[5] This can be due to lack of patient education. Some patients are able to differentiate between complaints where they can utilize the urgent care vs. coming to the ER.

The stakeholders are going to be patients, hospital ED staff such as the nurses, hospital administrators and the physicians and government funding towards healthcare. Long ER wait times decrease patient satisfaction as well as ER staff ratings. Patients might assume the providers are not efficient enough or neglecting their duties. They might question physician competency. The ER staff have to be willing to see the problem and address it. Providers are already overworked, especially in the ER, so adding the pressure of keeping wait times in mind might not be appealing to these providers. Quality of care provided can also be questioned if providers are expected to “rush”. When it comes to funding healthcare, when patients leave without being seen due to the wait time, they are more likely to return with a worsening concern which increases the national healthcare cost. Therefore, it will be in the insurance companies' best interest to work toward decreasing the wait times so that people can be treated before their health starts to significantly deteriorate.

Policy Options:

Provide financial incentives/bonuses to hospital ER staff for keeping average patient wait time low→ The ER staff can be divided into two teams and at the end of the month, the team that has lower average wait time will receive a financial incentive added to their salary from Medicare/medicaid.

Pros- Patients will receive care faster and any adverse effects due to the long wait time can be potentially eliminated. Does not require time to implement or train. Patients will be more satisfied with their care as well. The system is already in place. Medicare and medicaid already rewards hospitals for keeping costs low such as for lower readmission rates and other outcome based incentives. Providers and triage teams compete among themselves to be efficient through establishing better team work.

Cons- ER staff might put quantity over quality of care. They might discharge patients without ensuring the best quality of care was provided in order to clear beds for new patients. Providers are already overworked in the ER, the added pressure of having to keep time in mind might add on to the problem. Healthcare costs are already high, so Medicare and Medicaid might not pick up on this added cost.

Team triage and fast track treatment-

As discussed above, traditional triage is done by nurses. Nurses might make a mistake in prioritizing patients due to lack of training or experience, adding on to wait time. With team triage, a group of providers, nurses and ER technicians can see the patient as they register. Care can start right away if the complaint is not emergent. Patients with emergent cases can be taken down to the fast track lane for more emergent problems.

Pros- After being triaged, patients' first point of care will be with providers so treatment can start quicker. Separating non urgent cases and providing the right care faster can decrease crowding in the ER, which is a big reason behind longer wait times. Team-based approaches may

lead to fewer medical errors. This approach has been done before and studies show that it is effective. In one study, a retrospective review before and after the implementation of a team triage process showed a significant increase in discharges and a decrease in length of stay to discharge without evidence of increased testing[6].

Cons- Requires more healthcare providers, which are already limited in the ER. This approach also requires the staff to learn a new workflow which can take time to perfect. Lack of resources might not allow smaller hospitals to create a "fast lane" section. The patient's conditions can be unpredictable, even if a case might not seem emergent at first, it does not mean it will not become one.

Educate patients on utilizing their nearest urgent care/PCP for non-emergent cases→ Brochures can be given out in the waiting rooms of ERs

Pros- Crowding in the ER can be controlled if more patients visit the urgent care for non-emergent cases. Less crowding means less wait times. Educating patients on what symptoms they can go to an urgent care for will save them time as well. Most patients also get charged less for visiting an urgent care instead of an ER.

Cons- Patients have different levels of education. Many patients can not determine the severity of their symptoms or their condition might progress. Providers can not depend on patients to know the right thing to do. Some patients might still end up in the ER because they feel they trust the providers there more than at an urgent care or just for their peace of mind. Lastly, care can be delayed if the case is truly emergent and they eventually need to get transferred to the ER.

Recommendation: Judged on efficiency and timeliness

After considering all three options, I would choose providing financial incentives for reducing ER wait time as being the most ideal/realistic and beneficial, despite the cons. The idea is easy to implement, efficient and a new system does not have to be implemented. Providing incentives benefits the providers along with the patients, which the other options do not do. We can trust that providers prioritize the value of providing quality care even with the added responsibility of being efficient with their time. ER providers are already trained to be efficient and provide fast, effective care. One change to the policy we can make is, instead of saying low wait time, we can include a specific time frame. For example, keeping the wait time less than 20 minutes. This will ensure that we keep wait times low and provide quality healthcare. When it comes to Medicaid and Medicaid being willing to fund the incentives, we need to analyze data on how the cost benefits of providing incentives outweigh the risks. Longer wait times cause patients to leave the ER and their condition can get worse by the time they decide to visit another ER. Seeing the data of how this increases cost over time will push insurance companies to consider this method to save money in the long run.

References:

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