



Publishing Wait Times for Emergency Department Care

an Information Paper

*Developed by Members of the
Emergency Medicine Practice Committee*

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Introduction

The length of time patients wait to see a provider in the emergency department (ED) is an important driver of patient satisfaction.¹ Additionally, studies suggest that patients prefer to be provided with information and updates regarding their progress during the ED visit.^{2,3} In response, many EDs have begun communicating estimated wait times to the general public as part of their marketing strategy, using such methods as billboards, websites, and smart phone applications.^{4,5} Others have decided to display their wait times as an attempt to manage arrivals among multiple EDs within a given geographic area. A number of products, marketing companies, and computer applications have surfaced to assist in determining and displaying ED wait times, but their relative effectiveness, safety, and integrity remain a topic of much debate.^{1,6,7,8}

There is a dearth of information in the literature exploring the practice of publishing ED wait times, and no universally agreed-upon definition of wait time or method of measurement currently exists. Whether publication of ED wait times has a positive or negative effect on various aspects of patient care and ED operations has engendered significant interest and concern within the emergency medicine community.^{3,9,10} Given the paucity of evidence-based literature focusing on such an important topic, ACEP's Emergency Medicine Practice Committee (EMPC) members pooled their collective expertise to create an informational framework assessing the pros and cons of publishing ED wait times.

Pros

Advertising estimated ED wait times offers significant potential advantages for individual EDs and hospital systems. Promoting a relatively short wait time may serve as an effective marketing tool to divert additional patient visits from competing institutions. If an ED is in a particularly competitive market with a favorable patient payer mix, this tool may generate additional revenue for the system. Publication of desirable wait times also engenders good will with hospital administration and improves the image of the ED within the surrounding community. Advertisement of wait times offers an additional potential benefit to hospital systems that own multiple EDs within a circumscribed geographic area. Patients viewing wait time data for each ED may self-triage to the ED with the shortest wait time, thereby assisting in more evenly distributing the patient load among the system's hospitals and temporarily decreasing arrivals for an overburdened facility. In essence, the practice of publishing wait time data may theoretically assist with workload distribution, without losing revenue for the system as a whole. The potential benefits of published wait times for patients include the ability to select EDs with shorter wait times, the option to defer care until wait times improve for less urgent complaints, and the ability to inform family members and friends of anticipated delays.

Advertisement of ED wait times is often accompanied by a guarantee to be seen by a provider within a certain period of time. (30 minute "door to doctor" time, for example). In addition to the marketing advantage offered by publishing current wait times, advertising guaranteed maximum wait times may confer several other benefits to patients and EDs. Implementation of a guaranteed maximum wait time that is shorter than a given facility's historical door-to-provider time will necessitate significant operational changes within the ED. If a shorter door-to-provider time is achieved, the ED can expect improvements in left-without-treatment rates, patient satisfaction, and various time-based performance metrics such as time to antibiotics for pneumonia patients. Shortening the time to see a provider offers other patient safety benefits such as earlier recognition of potentially unstable patients, and earlier initiation of diagnostic testing and treatment. Finally, if initiation of a maximum wait time guarantee is

accompanied by broad-based support from hospital administration, the program can serve as an impetus for multidisciplinary process redesign. For example, the laboratory and radiology departments may be expected to decrease turnaround times, and efforts to minimize boarding may be augmented in order to enable the ED to meet the guaranteed maximum wait time. Ideally, the practice of ensuring reasonable door to provider times becomes ingrained in ED and hospital culture, and providers, staff, and administration work in concert toward this common goal.

Cons

There is much discussion regarding the problems associated with advertising ED wait times. The arguments against this practice cite ethical, patient safety, and operational reasons.

One major ethical concern centers on the lack of uniformity in defining, measuring, and communicating wait times (ie, some hospitals may learn to “game the system.”) While the Emergency Department Benchmarking Alliance defines provider contact time as “the time of first contact of the EMTALA-qualified provider to initiate the medical screening exam,”¹¹ the definition of “provider” actually utilized by EDs may differ, with some considering the provider to be the attending physician, while others consider the triage nurse, resident, nurse practitioner, physician assistant, or even hospital greeter as the provider for purposes of wait time determination. Significant variation in the depth and quality of the initial interaction with the patient also exists, leading to further questions. Does wait time measure door to greeting, door to triage, door to medical screening examination initiation, door to room, or door to treatment?¹² There is also a lack of standardization regarding the method of wait time measurement and display. For instance, some EDs utilize mean wait times while others utilize medians. Some update their data every two minutes, while others update in 60 minute intervals. No standard exists regarding how current the posted data must be or what segment of the ED census must be included in the measurement. For example, the measured time may reflect all ED patients or only certain segments, eg, ESI Level 3.¹³

Perhaps as a result of this lack of standardization, some confuse wait time with turnaround-time.^{5, 14, 21} Many advertisers compare their posted time in relation to the 4-5 hour average “wait time” reported in these reports. A 2009 Archives of Internal Medicine article claims median wait times of 22 minutes in 1997 and 33 minutes in 2006 likely more accurately reflect the true comparison group.²² If we as providers are perplexed, what is the patients’ perception? Another ethical concern arises when considering the target audience of wait time advertisements. Advertising short or guaranteed maximum wait times may increase ED visits, leading to additional hospital admissions, testing, and even outpatient referrals. Some suggest that such marketing targets mostly paying patients.¹⁶ Others insist marketing targets all patients, regardless of their ability to pay or perceived appropriateness of ED utilization. Medicaid agencies are eyeing this marketing strategy in light of over-utilization and cost-containment.¹⁷ With the cost of advertising as much as \$10,000 per month per billboard, some question whether or not this represents a judicious use of limited health care dollars.¹³

The patient safety argument against advertising ED wait times includes the concern that patients with emergent conditions may delay care as a result of viewing extended wait times. As discussed above, posted wait times can be misleading.^{18, 19} Consequently, patients may bypass a closer ED or delay presentation due to posted times. If the patient has a time-critical illness, significant disability or death could result. Others have noted the potential for providers to deliver lower quality or cursory assessments in an attempt to shorten the wait time or meet a certain maximum wait time guarantee, leading to a negative impact on patient care.²⁰ Any process abbreviation or bottleneck work-around that overlooks acuity or allows less acute patients to be cared for more expeditiously than higher acuity patients puts those higher acuity patients at risk. Processes created to meet maximum ambitious wait time guarantees may also necessitate more interruptions in provider workflow and handoffs between providers, introducing additional patient safety hazards.

Legitimate operational arguments against posting estimated or guaranteed ED wait times also exist. Obviously, if EDs are not prepared to handle an increased census resulting from posting desirable wait times, the system may quickly become overwhelmed. Promised maximum wait times may become impossible to meet, lengths of stay may increase, and public and hospital administration perception of the ED may suffer. The handoffs and interruptions introduced by providers struggling to meet wait time goals may also lead to other inefficiencies and/or prolonged overall ED lengths of stay. Considering a more global perspective, ED wait times are a symptom of larger process issues. Simply pulling providers away from their current task to see a newly arriving patient, placing a physician or mid-level provider in triage, or creating initial assessment teams may produce shorter wait times, but may not lead to shorter overall length of stay.¹² Work-around measures implemented to reduce wait time simply increase workload by pulling more patients into the system. Without creating mechanisms to ensure efficient throughput, the true underlying cause of prolonged door-to-provider times will remain unaddressed.

Conclusion

Literature examining the advertisement of estimated or guaranteed maximum ED wait times is scant and more research is required to adequately explore the potential advantages and disadvantages associated with this evolving practice. While publishing wait times may offer benefits such as expanded market share, increased patient satisfaction, and improved operational metrics, the potential for significant unintended consequences also exists.

Until further study is conducted, several actions are recommended to minimize risks to patients and EDs. ED wait time should be defined universally as the “door to qualified medical provider” time.¹¹ Wait times should have a disclaimer that they do not apply to patients presenting with a potentially life threatening illness, such as chest pain, so that patients do not feel that there is a perceived barrier to receiving care at the facility that is closest/appropriate to their location. Advertised wait times should be as accurate as possible, and updated at least hourly in order to remain meaningful. In order to safeguard patient safety, and in the spirit of transparency, clear explanations and education should accompany any communication of wait times to the general public. Finally, implementation of any ED wait time advertisement initiative should be accompanied by broad-based hospital administration support and should address the underlying operational inefficiencies which ultimately effect the ED wait time.

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