

To: Dr. Stuart G. Kessler, Director of the Department of Emergency Medicine
From: Kevin Zhang
Date: July 25th, 2025
Re: Reducing Emergency Department Wait Times at Elmhurst Hospital Center

Statement of Issue

Elmhurst Hospital Center (EHC) stands at the heart of Queens, serving one of the most diverse and populated communities in New York City. Each year, its emergency department (ED) sees over 130,000 patients, which is more than triple the volume it was originally designed to handle.¹ This heavy load not only puts constant pressure and stress on providers but also results in overcrowding and longer wait times for patients to be seen. Currently, the average wait time at EHC's ED is approximately five hours, which is the longest in Queens and nearly double the national average.² Studies have shown that these extended delays are associated with decreased patient satisfaction, increased rates of morbidity/mortality and complications, as well as a higher likelihood of patients leaving without receiving care.³ The latter has been linked to a 14% higher risk of 7-day death or hospitalization and 5% increased risk of 30-day death or hospitalization.⁴ Therefore, it is important to implement effective policies that reduce ED wait times to better meet the needs of the community.

Policy Options

1. Optimize the existing Provider in Triage (PIT) model → The PIT model involves placing a physician, nurse practitioner, or physician assistant at the triage area of the ED to perform rapid evaluations and initiate basic tests/treatments immediately upon a patient's arrival. Although EHC already has this model in place, it can be fine-tuned. This includes increasing the number of providers assigned to triage, adding more scribes for documentation purposes, and integrating a tele-triage service (where off-site providers can do live video consults to help with patient assessments and triage decisions).

Advantages – Having more providers in triage, whether physically or virtually, helps patients get evaluated faster. Adding scribes can allow providers to focus solely on patient care and decrease the time that they spend on administrative work. Well-executed PIT models have been shown to reduce patients leaving before treatment completion by 39% and those leaving before seeing a provider by 69%.⁵

Disadvantages – Increasing the number of providers/scribes and using tele-triage require both funding and training. Adding more team members can initially cause workflow confusion. Some patients may be reluctant to discuss matters through a screen. Physical exams are also limited via tele-triage.

2. Community education campaigns → A recent study found that 60% of ED visits are “primary care eligible”, meaning that the patient's condition could have been managed in an appointment-based setting rather than requiring emergency care.⁶ EHC can launch community education campaigns to help patients better understand when to use the ED versus when to choose other options like primary care or urgent care. This can be done through multilingual social media posts, printed flyers/posters placed throughout the community, and interactive workshops.

Advantages – Helps keep non-emergency cases like minor ankle sprains away from the ED, which frees up resources for more urgent cases. Increases community awareness and health literacy. Reduces ED overcrowding. Lowers overall healthcare costs for patients since primary care and urgent care are generally more affordable.

Disadvantages – Some patients may still choose the ED out of convenience or habit. Behavioral changes take time, so ongoing efforts are required. Campaigns may not reach all community members equally, especially those without internet access or with lower health literacy. Primary and urgent care clinics are typically not 24/7.

3. **Incentivize timely provider response** → Performance-based bonuses (rewarding door-to-provider times that are under one hour) or even non-monetary rewards (additional paid time off or priority in choosing shifts) can motivate providers to see patients quicker and help to lower wait times.

Advantages – Easy to implement and does not require additional training. Increases patient satisfaction since they are getting treated faster. Reduces patient walkouts and overcrowding.

Disadvantages – Incentives overemphasize speed and quantity, which can lead to increased provider stress and risk of burnout since they are constantly on the move. As a result, overall quality of care may be compromised. May also create a competitive work environment rather than a collaborative one as all are trying to meet individual targets. Providers with more complex cases are at a disadvantage.

Policy Recommendation

Out of all the options mentioned, incentivizing timely provider response through a combination of performance-based bonuses and non-monetary rewards is the most practical. It requires no major systemic changes or extensive training. It also builds on existing incentive structures like the Medicare Value-Based Purchasing Program which providers are already familiar with. Having more than one form of incentive not only boosts team morale but also encourages consistent performance, which can help to improve the hospital's reputation in the public eye. However, one important thing to note is the funding. While this approach is much more affordable compared to the other two, it does require upfront financial planning. In other words, internal funds may need to be reallocated (such as moving budget from non-essential administrative expenses like outdated technology subscriptions or unnecessary facility upgrades) to support the initial implementation of the program.

References

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