The False Dichotomy Between ED Multifunctionality and Efficiency

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Focusing exclusively on ED throughput obscures crucial (and probably irreversible) changes to the Emergency Care operating environment.

By Caio Vahanian and Daniel Dellaferrera

The role of Emergency Care in general and of Emergency Departments in particular within the care continuum has been discussed for decades. The ED even occupies a privileged space in pop culture, with millions of TV viewers following the lives of fictional (and usually very attractive) nurses and doctors in weekly installments, courtesy of Michael Crichton and R. Scott Gemmill.

As deep as laypeople's understanding of Emergency Care may seem thanks to those TV shows, the reality is even more complex (though driven by somewhat boring data rather than by workplace romance).

One of us got started in healthcare by running back-to-back research studies covering hospital discharge efficiency and Emergency Department optimization in subsequent years. This made it easy to find non-obvious connections between the metrics associated with two processes that are usually analyzed separately. The fundamental (and, so far, evergreen) conclusion of that assessment was that **perceived ED inefficiency is often the most visible and painful symptom of actual inefficiency elsewhere**. We already covered the **damage done by forcing EDs to operate as 'hospitals within the hospital' (i.e. Boarding)**, but that is only one of many examples. Thorough root cause analyses that determine the true culprit instead of increasing pressure on already overworked ED teams are absolutely crucial.

During the aforementioned study cycle focused on ED efficiency, a Chief Medical Officer mentioned during a research interview that his ED doubled as his hospital's *'Marketing Department'*. Though puzzled by the statement at first, subsequent sleuthing by the research team revealed that in that particular country, **ED presentations were the first interaction with health systems for 80 percent of patients (and the only interaction for 60 percent of them)**. In short, either the first or the only impression most patients got about a health system would originate during ED-based instances of care. We believe this is worth highlighting because it adds one extra layer of complexity to the already complicated task of defining and measuring what constitutes "efficiency"

in Emergency Care. The country in question operates in an almost pure fee-for-service environment where privately insured patients are concerned. This creates a contradiction between clinical efficiency and financial efficiency metrics because Triage 4 and 5 patients who, strictly speaking, don't need emergent or urgent care, are also the ones most likely to have the most generous sources of reimbursement.

Our recommendation is that all discussions about ED efficiency start with a single agreed-upon definition for "efficiency" and the metrics involved. A commendable second step would be to acknowledge the widening gap between the original purpose for which EDs were designed and the way in which they are currently used. Most of the available research shows that EDs have effective and efficient processes in place for Triage 1 and 2 patients, while they perform less well when confronted with growing volumes of patients whose psycho-social needs far outweigh their clinical acuity. While it would be tempting (and directionally correct) to draw a link between this challenge and **EMTALA**, we also need to acknowledge this mismatch is not exclusive to the United States. If you'll forgive our toolbox analogy, you can't blame a socket wrench for underperforming when you try to use it to drive nails into a piece of wood.

This feels difficult enough already, but we'd be remiss if we didn't also mention that the agreed-upon definition we suggested above cannot be a static one. It not only has to evolve in order to match changes in patients' needs, but a key component of that evolution will be our **ability to periodically update what constitutes an appropriate ED presentation**. A recent **report** from **Advisory Board** argues convincingly that acuity and urgency-based criteria are no longer enough on their own to determine whether a presentation should be counted as appropriate. With robust data backing them up, they state that patients suffering acute exacerbations from chronic conditions belong in the ED. Even though this is a significant difference from Advisory Board's own seminal research on Emergency Care, the way in which healthcare actually runs (and gets funded) in 2025 prompts us to agree with that opinion.

We cannot expect ED teams to excel if we continue throwing confusing and contradictory performance metrics at them. We cannot expect them to succeed if we fail to support them with appropriate resources for the challenges they face and the patients they help in 2025 and in the foreseeable future. We believe in their clinical capabilities, which in turn means our support must serve as their reliable and user-friendly radar screen and navigation system. If the aim is to give them back the bandwidth that will allow their clinical skills to shine, then advanced data analytics and AI are the best tools we should put in their hands.