

AN EXECUTIVE EBOOK

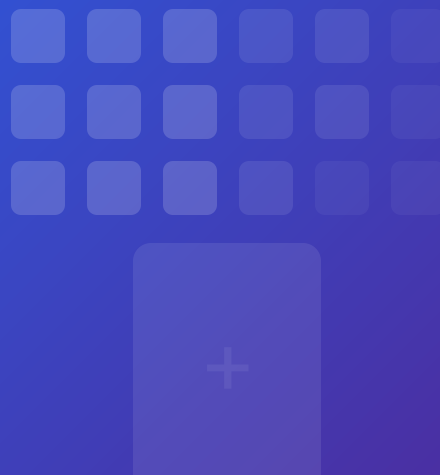
Patient Experience Starts in the ED

Why ED experience deserves the same resourcing,
urgency, and executive attention as every other
department in the hospital

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vital



Patient Experience Starts in the Emergency Department

An executive ebook, adapted from the full Vital strategic memo

Emergency department experience is usually treated as a clinical team's problem and a secondary line item. The evidence says otherwise. This ebook distills the full findings, published research plus Vital's own analysis of roughly 310,000 real ED visits, into the numbers and actions that matter most for a patient experience or quality leader making the case for change.

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ABOUT THIS EBOOK

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CHAPTER 1 · INTRODUCTION

Introduction: at a glance

Roughly seventy percent of daily hospital admissions in the United States now begin in the emergency department. HCAHPS, the survey tied to Value-Based Purchasing dollars, already adjusts for ED-admission status because CMS has measured that this single fact moves hospital scores. And yet the ED is consistently the last floor to get additional staffing, the last to get a capital refresh, and the only floor whose entire patient population is largely invisible to the metric most systems are actually accountable for.

This ebook makes the case in four parts: what actually drives poor ED experience scores and why the number a hospital sees understates the real problem; why the ED already sits at the center of hospital finances in plain dollar terms; what roughly 310,000 real ED visits inside Vital's own partner network confirm about all of this; and a concrete set of actions any patient experience or quality leader can start on this week.

AT A GLANCE

70%

of daily hospital admissions start in the ED

<2%

of ED patients ever complete an experience survey

\$1.9B

paid annually through Medicare's VBP program

3.5x

more score impact from pre-provider wait

Each of these numbers is explored in full in the chapters that follow, along with what they mean for how a health system should staff, measure, and resource its emergency department.

The ED is the only floor whose entire patient population is largely invisible to the metric most systems are actually accountable for.

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CHAPTER 2 · THE PROBLEM

A score that hides the real picture

What actually drives the score

- Communication clarity is the single strongest predictor of satisfaction across the published literature. Patients who understand what's happening tolerate long waits far better, even when the underlying care is identical.
- Boarding is the fastest-growing driver nationally. Patient-reported diagnostic-quality scores fall from an average of 4.10 (of 5) in the shortest-stay quartile to 3.79 in the longest.
- Patients who leave without being seen are, by definition, excluded from every survey, and carry a well-documented elevated risk of subsequent ED return, hospitalization, and mortality.
- None of this is new strain: the ED's share of hospital admissions and hospital economic activity has climbed for twenty-five years, while HCAHPS, the instrument measuring the result, hasn't been rebuilt to reflect it.

Why the score understates reality

- In the largest single-ED study of its kind, completed surveys existed for fewer than two percent of all patients treated, skewed older, more female, and more privately insured than the ED itself.
- ED CAHPS only surveys patients discharged directly home. Boarded and admitted patients, often the ones with the hardest visit, are excluded from the instrument by design.
- The bias is worst exactly when it matters most: on the most crowded days, the most dissatisfied patients walk out and vanish from the eligible sample entirely.
- ED-admitted patients respond to HCAHPS at roughly half the rate of clinic-admitted patients (18.4% vs. 35.6%), softening any gap a hospital does manage to see.

The score that makes it to the desk of a hospital executive is almost certainly an underrepresentation of the true state of affairs.

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CHAPTER 3 · THE BUSINESS CASE

Real dollars, already on the table

The dollars already at stake

- HCAHPS, tied to Hospital Value-Based Purchasing dollars, explicitly adjusts for ED-admission status because CMS has measured that it moves hospital scores.
- VBP withholds 2% of Medicare inpatient payments nationally. For an average hospital that's roughly \$750,000 a year in the pool; for a large academic center, closer to \$3 million.
- A one-point rise in HCAHPS Star Rating is associated with an 8.8% increase in net patient revenue per discharge. Online reviews capture exactly the population every survey misses.
- The ED is the unscheduled front door to a system's own highest-margin patients: 9.8% of joint-replacement patients visit the ED within 90 days of surgery, and a treatment-related oncology ED visit costing roughly \$800 can prevent a \$22,000 admission.

What Vital's own data confirms

- Across roughly 310,000 real ED visits, top-box experience scores fell from 66.9% in the fastest length-of-stay quintile to 32.7% in the slowest, replicated across two survey vendors and two age groups.
- The wait before seeing a provider costs 3.5 times as much score as an equivalent wait after provider contact. Faster triage alone barely moves the number.
- Patients form their verdict early: those who later left without being seen showed a measurably lower real-time sentiment score than patients who were ultimately discharged, a live warning sign while a clinician can still act.
- Once age and sex are accounted for, race is not an independent predictor of score. The demographic gap many systems observe is substantially a response-rate artifact, not differential care.

The team that isn't there yet to assemble the cath lab at 2 a.m. is the same team that isn't there yet to explain to a frightened family what's happening while they wait.

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CHAPTER 4 · WHAT TO DO

Four levers, one accountable owner

1. Manage the wait, even before you can shorten it

Give, and update, a wait-time estimate. A field experiment found satisfaction rose roughly 21% from this alone, independent of whether the wait itself got shorter. Communicate proactively during boarding specifically; it's the single highest-leverage moment to intervene.

2. Treat boarding as a hospital-wide flow problem

Extend existing bed-huddle governance to cover the communication consequences, not just the logistics. Set boarding-hour targets aligned to CMS's Age-Friendly Hospital measure: under eight hours total ED stay, admission within three hours of the decision to admit.

3. Staff for the demand pattern you actually have

Re-point existing patient-experience and rounding staff toward the ED specifically, since most currently round during the day on inpatient units, the opposite of when the experience is actually decided. Give that staff a tool built for ED workflows, not repurposed inpatient logic.

4. Fix the measurement, not just the operations

Reach the population the official survey structurally misses with a broader-reach, multilingual, in-visit capture method. Track boarding hours and LWBS rate as standing operational metrics alongside the survey score, since they capture what the survey doesn't.

We recommend that a single leader owns boarding hours, length of stay, LWBS rate, and HCAHPS together on one scorecard, reviewed in the same executive cadence as OR utilization and discharge planning.

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CHAPTER 5 · ABOUT VITAL

About Vital

Vital is a real-time communication and patient-experience platform inside emergency departments, connecting patients and care teams during the visit itself rather than after it. Across Vital's partner network, the platform reaches roughly 65 to 70 percent of ED patients directly, in 20 languages, across more than 200 hospitals.

Patients who engage spend an average of 35 minutes of their ED visit inside the application, not a passive notification checked once, but sustained use across test results paired with patient education, AI-driven tools, service check-ins and requests, and algorithmic patient-experience targeting that flags which patients need staff attention most urgently on a given shift.

The findings throughout this ebook are drawn from that reach: roughly 310,000 real ED visits across three partner health systems, spanning two survey vendors and both adult and pediatric populations, built to close the exact measurement and communication gaps this ebook describes.

65–70%

of ED patients
reached directly

20

languages
supported

200+

hospitals across
the network

35 min

average time in-
app per visit

LEARN MORE

To see how Vital could apply to your emergency department, or to request the full strategic memo with complete citations, visit vital.io or contact your Vital representative.



**Beautiful, intelligent
software for patients and
providers.**

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