January 2026

The hidden cost of 'good enough'

Why average performance in the ED jeopardizes patient safety, margins and morale

For many health systems, the emergency department (ED) is the front door. Patients seeking emergency care arrive expecting timely care. Their ED experience often shapes their trust and impression of the organization.

In the ED, operational discipline matters greatly. Yet many EDs operate at merely average performance, meeting basic standards but falling short of true operational excellence. Performance at these EDs is generally comparable to peers, neither notably deficient nor exemplary; it's "good enough," according to national benchmarks across key indicators such as door-to-provider time and left-without-being-seen (LWBS) rates.

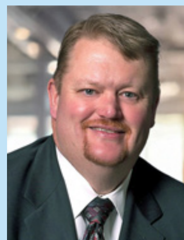
That is precisely the problem. Average ED performance is not neutral. It is a decision to tolerate risk, leakage, patient dissatisfaction and variable quality of care. It exposes patients to avoidable harm, quietly erodes margin and accelerates workforce fatigue, while signaling to patients that mediocrity is an acceptable standard.

Three realities explain why average ED performance is worse than it appears.

1. **The waiting room is one of the most dangerous places in the hospital**

   It may sound counterintuitive, but the ED waiting room represents one of the highest-risk environments in healthcare. In an average-performing ED, patients routinely wait more than an hour before being evaluated. Triage systems identify obvious emergencies, but they cannot replace a differential diagnosis by a clinician. Subtle, time-sensitive conditions (e.g., compensated sepsis, occult myocardial infarction, aortic aneurysm) do not declare themselves at arrival; they require clinical judgment, pattern recognition and timely evaluation.

   Every additional minute between arrival and clinical evaluation increases risk. At the same time, prolonged waits tell patients that the system is overwhelmed.


Roy Boland
Vice President

Amanda Gallegos
Assistant Vice President

Tracey Szewczyk
Vice President

LWBS rates rise, but patients who leave without being seen are not being impatient or unreasonable. They are responding rationally to what the ED is telling them. The ED's message: we can't keep up.

LWBS rates often are framed as an unfortunate but unavoidable byproduct of volume. In reality, they are a quality metric. Many average EDs operate at a LWBS rate of 4% or higher, with many hospitals operating at even higher rates.

For a 60,000-visit ED, a 4% LWBS rate equates to roughly 2,400 patients leaving annually. Even at conservative reimbursement estimates, that loss, at an average of $600 in net revenue per visit, represents more than $1.4 million in lost revenue including potential inpatient admissions and downstream services, not to mention damage to brand loyalty.

In high-reliability EDs, performance is anchored in a set of disciplined metrics that are used to drive consistent results. These EDs consistently report median door-to-provider times under 20 minutes and LWBS rates below 1%. They use predictability models, real-time visibility and early intervention to limit deviations. They sustain this level of performance through tightly aligned physician and nurse collaboration as well as active, hospital-wide support for bed-capacity constraints.

© Kaufman, Hall & Associates, LLC, 2026. All rights reserved.

2. Staffing to averages guarantees average outcomes

One of the most common structural drivers of mediocre ED performance is how staffing decisions are made. Too often, they support complacency toward staffing to plan. Many EDs staff to historical averages in daily volume, arrival patterns and acuity. But emergency care is defined by variability. Arrival patterns change by hour, day and season. Fluctuations can quickly overwhelm resources.

Understanding these patterns is an essential component of highly reliable operational performance. For the average ED, unsophisticated staffing models create predictable bottlenecks at the front end. The downstream effect can hamper ED throughput by prolonging length of stay, which delays diagnostic workups and leads to hallway care and frustration. Clinicians spend their shifts playing catch-up, an unsustainable pattern that drains morale and efficiency.

ED performance follows queueing theory: as volume nears or exceeds capacity, wait times and delays increase exponentially, not linearly. Over time, the consequences compound.

There is a long-term effect of traditional staffing models. Emergency medicine already faces some of the highest turnover rates in healthcare. Replacing a single physician or nurse routinely costs six figures when recruiting expense, onboarding, lost productivity and ramp-up time are considered. While many average EDs blame staffing shortages, their own workforce model often fuels the burnout they're trying to fix.

> **Sustained excellence requires relentless reinforcement, visible leadership and a culture that defends gains rather than celebrates them prematurely.**

High-reliability EDs take a fundamentally different approach. They staff to demand, not to historical averages, with attention to patient arrival variability and predictable surges. These organizations leverage time-based data to anticipate fluctuations and proactively align resources such as treatment space, direct care nurse capacity and provider capacity.

Central to this model is tiered physician and nursing collaboration, in which clinical roles are clearly defined and dynamically deployed based on patient acuity and volume. Physicians, nurses and support staff operate in coordinated tiers that expand or contract as demand shifts, ensuring that care teams are positioned ahead of need rather than mobilized reactively once congestion has already formed. This proactive, tiered approach enables earlier patient engagement, smoother throughput and sustained high performance across key ED metrics.

Performance Level	Median Door-to-Provider Time	LWBS Rate	Comments
High-reliability ED	Less than 20 minutes	Less than 1%	Excellent front-end flow, proactive triage processes
Typical/average ED	25 to 45 minutes	3 to 5%	Reactive staffing, moderate bottlenecks at triage
Underperforming ED	More than 60 minutes	Greater than 5%	Chronic crowding, fixed staffing, high patient walkouts

© Kaufman, Hall & Associates, LLC, 2026. All rights reserved.

3. **Average performance reflects a management system failure**

   The most defining characteristic of an average ED is the absence of a disciplined, data-driven management system.

   Many EDs are overwhelmed by large volumes of data without clear insight into what those data mean or what actions should follow. This lack of clarity leaves staff uncertain about how metrics connect to their daily work and how they can contribute to improvement. Key performance data must be captured, reviewed and acted upon regularly. When teams understand the story behind the data, they can focus on the vital few metrics that drive sustained improvement.

   High-reliability EDs address this gap by establishing a clear strategic focus set by leadership. Data is visible, and teams review it throughout the day. When performance is consistently reviewed and understood at all levels, teams are aligned, engaged and equipped to be part of the solution. Leaders and front-line staff should see performance drifts before patients do and promptly realign actions to level-set performance.

Why early wins are only the beginning, not the destination

There is good news and bad news when it comes to ED process improvement. The good news: when organizations commit to improving ED performance and frontline care teams are on board, results often arrive quickly. Front-end redesign, staffing realignment and focused leadership attention can produce dramatic gains in weeks.

Unfortunately, early gains can create the illusion that the problem has been solved, prompting attention to shift and operational pressure to ease. Without sustained focus, the system gradually drifts back toward its prior state. Sustainable performance is achieved not through early improvement alone, but through the discipline to maintain, standardize, and build upon those initial wins over time.

These actions can lead to rapid ED improvement

- Aligning staffing to real-time demand, not historical averages
- Embedding live performance dashboards visible to all stakeholders
- Conducting daily flow huddles with frontline input
- Reinforcing accountability around leading indicators

As with any quality improvement journey, there is no steady state in ED performance. Organizations are either improving or regressing. Sustained excellence requires relentless reinforcement, visible leadership and a culture that defends gains rather than celebrates them prematurely.

The leadership challenge

Most EDs can achieve substantial, durable improvement within three months by focusing on intentional system redesign. When adopting standard work, it can take six to 10 months for the habit to stick during busy periods. Consistency over time, not quick wins, turns a new behavior into a lasting habit.

The return is meaningful: safer care, shorter waits, stronger margins, lower turnover and a calmer, more predictable environment for patients and staff. More importantly, the organization sends an unmistakable message to its community and workforce: average is not acceptable.

The conditions that created overcrowded waiting rooms in the first place are either tolerated or not at the executive level. Fixing them requires a commitment to stop normalizing dysfunction and manage the ED with rigor. Good enough may feel comfortable, familiar and safe. But it costs far more than executives might realize. Average ED performance is not good enough for patients, for staff or for the organization's future.

Questions? Contact Roy Boland (roy.boland@kaufmanhall.com), Amanda Gallegos (amanda.gallegos@kaufmanhall.com) or Tracey Szewczyk (tracey.szewczyk@kaufmanhall.com)

© Kaufman, Hall & Associates, LLC, 2026. All rights reserved.