

Your ECAT Readiness Playbook

8 Steps from Measurement
to Meaningful Improvement
That Go Beyond the ED



Whether your emergency department (ED) or hospital is prepared or not, the **Emergency Care Access & Timeliness (ECAT)** measure is coming.

As Alan Eisman, Senior Executive Advisor ESO and EDPMA Board Member, said:

“What we have long known to be a national public health crisis has now been elevated to a national priority with real regulatory teeth and increasingly significant reputational and financial consequences.”

The access and flow problems ECAT highlights are not new. Emergency department crowding, long waits, patients leaving before evaluation, prolonged boarding, and extended lengths of stay have challenged hospitals for years. What is new is the priority CMS is placing on these failures, particularly boarding, by bringing them together in a national composite measure with increasingly meaningful financial consequences.

This changes the equation for health systems. ECAT elevates emergency care access from a persistent operational challenge to an enterprise performance priority. Importantly, the financial opportunity associated with improving access, capacity, and patient flow can be substantial in its own right. ECAT adds urgency and accountability, moving this work higher on the organizational agenda.

The Emergency Care Access & Timeliness measure brings four related access failures into one view:

1



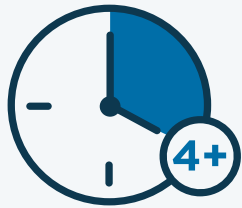
Waiting longer than an hour to be placed in a qualifying treatment space

2



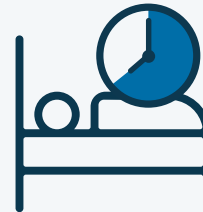
Leaving before evaluation

3



Boarding longer than four hours when admitted

4



Staying in the ED longer than eight hours, whether admitted, discharged, or transferred



An encounter that meets any one of these criteria is included in the composite numerator and fails the measure.

The numbers suggest that hospitals have plenty of work ahead. A 2025 JAMA Health Forum analysis applied an earlier version of the measure logic to more than **148 million** encounters in a national electronic health record database. At least one access failure occurred in **18.5%** of encounters in 2017. By 2024, that figure had climbed to **28.7%**.

CMS has finalized voluntary reporting for calendar year 2027, with mandatory reporting beginning with 2028 data for the 2030 payment determination. For now, the Hospital Outpatient Quality Reporting Program is pay-for-reporting. Failure to meet program requirements can reduce the annual payment update under the Hospital Outpatient Prospective Payment System (OPPS), but a poor ECAT score does not carry a separate performance-based penalty.

Knowing the aggregate score is only the beginning. To improve it, hospitals need to know which patients are crossing a threshold, where the delays are occurring, what is driving them, and the magnitude of each underlying problem.

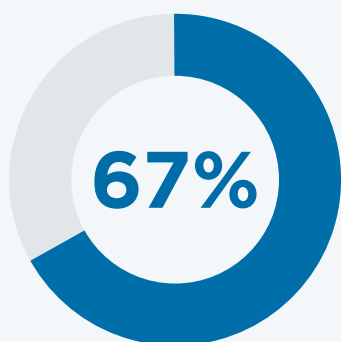
From here, potential changes need to be evaluated cross-functionally to determine which interventions offer the greatest value, while minimizing unintended consequences.



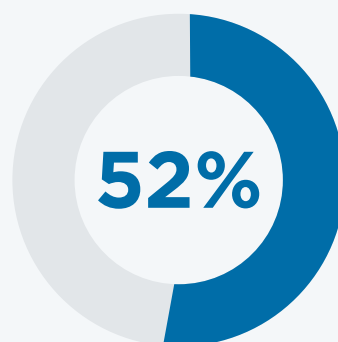


What We Heard From Emergency Medicine Stakeholders

In live polls during an Aug. 19, 2026, Emergency Department Practice Management Association (EDPMA) webinar:



of respondents identified
boarding longer than four hours
as their organization's greatest
current opportunity.



of respondents identified inpatient
nursing capacity as the greatest
barrier to reducing boarding.

Source: Respondents included representatives from emergency physician groups, hospitals and health systems, and healthcare service and technology organizations. These findings reflect the webinar audience and should not be interpreted as representative national research.

Those findings point to one of the central challenges of ECAT.
A failure may show up in the ED even when much of the cause sits elsewhere in the hospital. Hospitals need to look beyond the ED. Some upstream and downstream factors drive ECAT failures in the ED, while others result from them.

**The following eight steps provide a practical starting point.
Use this as your hospital's playbook for ECAT readiness.**

1

Establish Your Baseline Across All Four Components

Calculate exposure across all four components, not simply the aggregate result. Show the affected encounter count and rate for each component and track overlap among them. The official composite counts an encounter once even when several criteria are met. Operationally, those overlapping flags reveal whether one delay is creating several failures in the same patient journey. A patient who boards for more than four hours, for example, may also exceed the eight-hour length-of-stay threshold.

Before relying on the baseline, validate the data behind it.

Review the logic used to track:

- Arrival time
- Placement in a qualifying treatment space
- Clinician evaluation
- Decision to admit
- Admit order time
- Physical departure from the ED



This step is easy to underestimate. **If leaders and clinicians do not trust the underlying data, the first cross-functional meeting is likely to become a debate over whose report is correct.**

A baseline becomes useful only when the people expected to act on it believe it accurately reflects their patients and workflows.

At the end of this step, you should have:

- A count and failure rate for each ECAT component
- The overall composite result
- The number of encounters failing multiple components
- A view of encounters approaching each threshold
- A list of missing timestamps, questionable mappings, or other data-quality concerns
- A documented definition for each timestamp and treatment space used in the analysis

2 | Stop Managing Only to the Middle

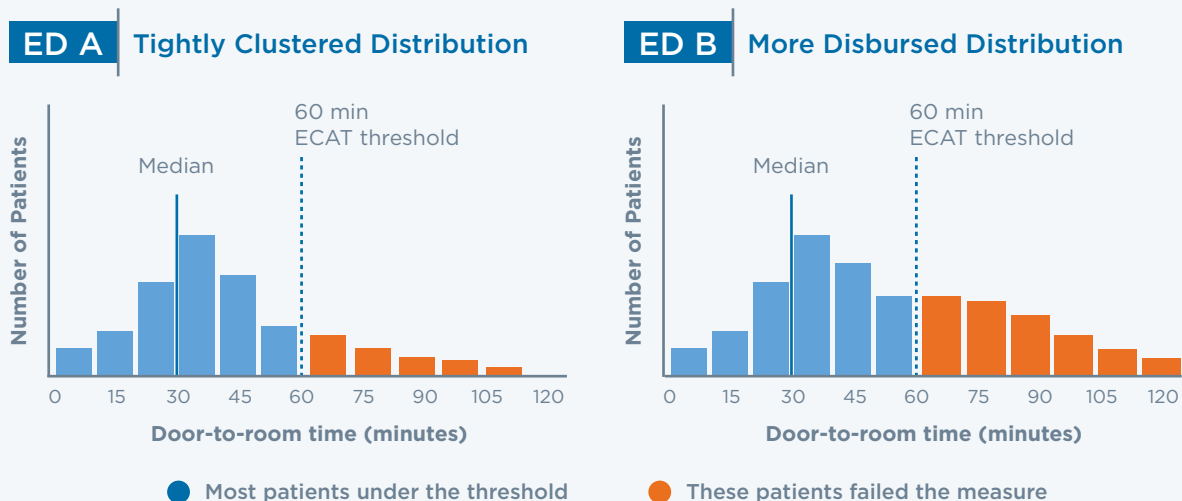
A median is not wrong. It is incomplete.

Two EDs can have the same median door-to-room time, but one has a tightly clustered distribution while the other has a substantial group of patients waiting beyond 60 minutes. The same is true for boarding and total length of stay. The summary statistic may be accurate yet mask the patients experiencing the most significant delays.

As Mark Canada, MHA, MSN, RN, d2i's senior vice president of integrated operations, said:

“We’ve been aiming at the middle, now we need to aim at the tail.”

To understand that tail, hospitals need to look at the full distribution and overlay the relevant ECAT threshold. Show how many encounters crossed the threshold, how far beyond it they went, and how many patients were approaching the threshold. Median, mean, and upper-percentile performance provide some important context, yet the patients at and beyond the threshold are what ultimately drive ECAT performance.



This view changes the conversation. Instead of asking only whether the median improved, leaders can see how many patients still experienced an excessive delay and how far beyond the threshold they went.

Near misses matter as well. Patients consistently clustering just below a threshold signal vulnerability. A relatively small change in volume, staffing, downstream capacity, or patient complexity may be enough to push a meaningful number of encounters across the line.

3 | Find the Tail

Once you can see the distribution, start looking for patterns among the patients who crossed the threshold.

Break the failures down by factors such as:

- Hour of day and day of week
- Emergency Severity Index (ESI) level
- Patient age
- Arrival mode
- Disposition
- ED zone
- Diagnosis
- Admitting service
- Inpatient destination



These internal views can help identify the source of a problem. Although they do not replace any stratification required by CMS, these additional stratifications greatly improve insight into when and where the opportunities lie.

Look at counts and rates together. Monday may produce the most failures because Monday has the highest volume. A smaller overnight window may have fewer failures but a substantially higher failure rate. Those are different signals and may require different responses. One may point toward a demand-capacity mismatch, while the other may suggest differences in staffing, workflow, resource availability, or downstream support.

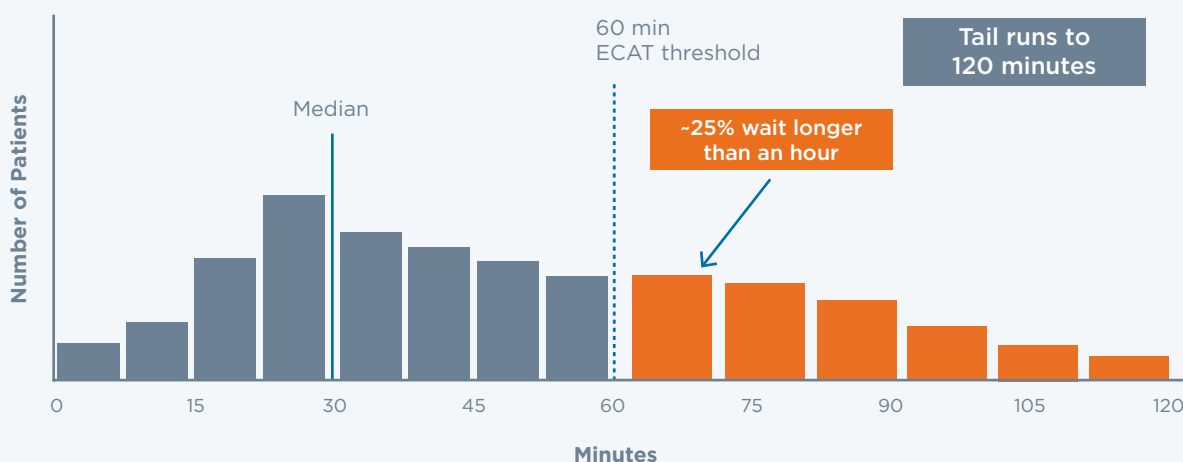
Avoid jumping to conclusions based on a single pattern. A higher failure rate within one shift, service, or patient group is a reason to ask more questions, not a verdict on an individual or department. Test the patterns against local workflows and talk with the people closest to the work.



The patients in the tail usually have something in common.

The goal is to find the recurring combinations of demand, workflow constraints, and capacity limitations that place patients at greatest risk of crossing an ECAT threshold. That is where the path from measurement to diagnosis begins.

Monday Door-to-Room Times



The median clears the hour. About a quarter of patients do not, and that tail is what stalls flow.

4

Identify the Component Creating the Greatest Exposure

ECAT combines four access failures into a single measure, but each component will contribute differently to overall performance at each hospital. Use the baseline and tail analysis to determine where the greatest exposure exists and where focused improvement is most likely to have meaningful impact.

Consider:

- ✓ How many encounters are affected
- ✓ The failure rate and whether it is improving or worsening
- ✓ Which patient populations are most affected
- ✓ The potential impact on patient safety and experience
- ✓ The magnitude and concentration of the underlying problems
- ✓ How well the root causes are understood
- ✓ The resources, operational effort, and change required to improve performance
- ✓ The potential benefit relative to the cost and complexity of the intervention



Examine where the ECAT components overlap. A high rate of visits longer than eight hours, for example, may largely involve the same patients who boarded for more than four hours. In that case, boarding may be the more useful place to begin.

Once the priority is clear, define the problem with enough specificity to guide analysis and action. “Improve throughput” is too broad. A target such as reducing four-hour boarding failures among medical admissions during weekday afternoons by 10% within 90 days gives the team a patient group, time frame, and outcome it can build tactics around.



Be wary of chasing metrics. Continue monitoring all four components while improvement work is underway. Success in one area should not simply shift delays, workload, or risk to another part of the patient journey. ECAT is a composite metric that is non-compliant if any one of the four operational thresholds is exceeded.

See What Is Driving Your **ECAT Exposure**

d2i helps emergency medicine leaders move beyond the composite score to see which patients are affected, where delays are occurring, and what is contributing to them.

[Explore Emergency Medicine Analytics](#)



5

Separate ED-Controlled Problems From System-Controlled Problems

The location of the failure is not necessarily the location of the cause.



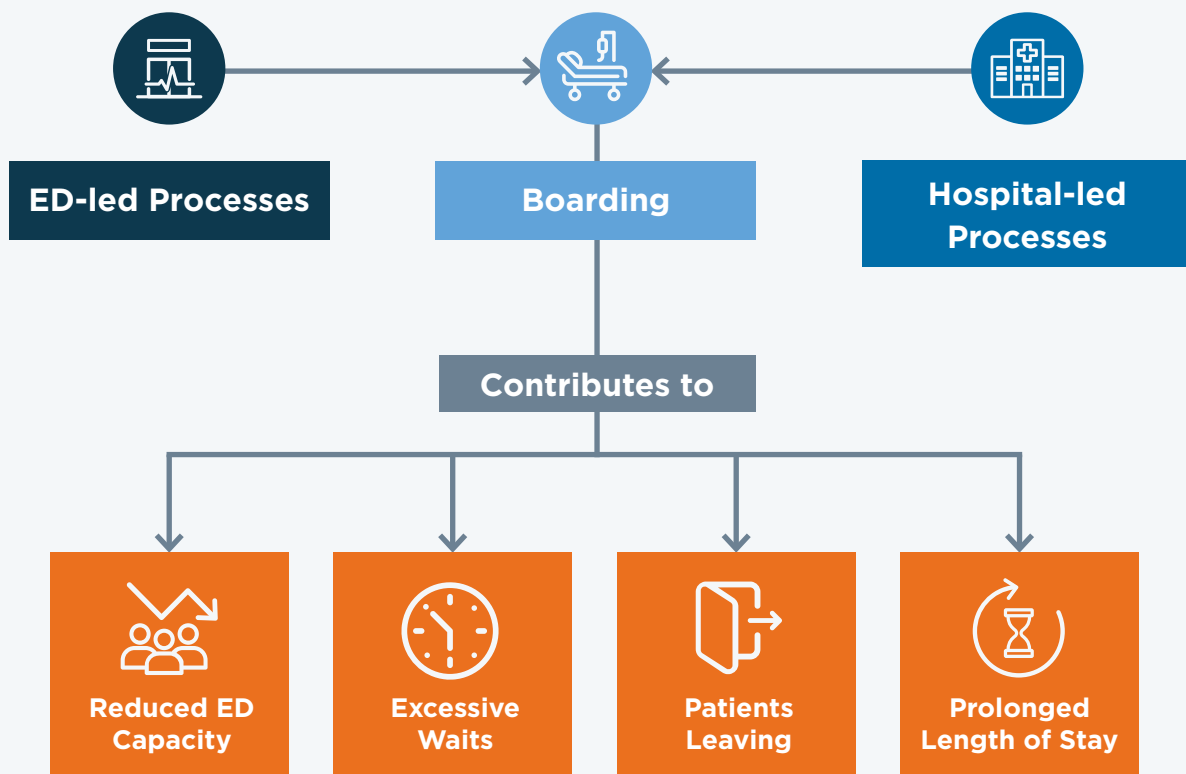
The **ED** has direct levers over triage, immediate bedding, low-acuity pathways, assignment to qualifying space, waiting room ownership, and escalation before a patient leaves.



Boarding is different because it is shaped by [hospital-wide capacity](#) and [patient flow](#). The ED can improve disposition timing and communication, but it cannot independently create a staffed inpatient bed.



Inpatient nursing capacity, discharge timing, bed assignment, environmental services, transport, and specialty capacity are **hospital-wide concerns**.



For example, evening discharge delays can increase the number of boarded patients occupying ED rooms, worsen the front-end queue, and make it more likely that other patients will leave. One system problem can therefore contribute to several ECAT failures.

As Mark Canada said:

“The ED is the canary, but the root cause is the system.”

For each problem identified in the data, determine which team controls the process that needs to change and which other teams influence it. The purpose is not to decide who deserves blame. It is to make sure responsibility sits with people who have the authority and resources to address the cause.

6 | Go Beyond the ED: Build Your ECAT Tiger Team

The ECAT tiger team should include clinical and operational leaders whose work directly affects patient flow.



At a minimum, the team should include:

- Executive sponsor
- Emergency medicine
- Hospital medicine
- ED nursing
- Inpatient nursing
- Command center/patient flow
- Bed management
- Case management



Command center, bed management and case management directly help manage the flow, but they are not the owners but rather support the diad leaders.

Emergency medicine should play a central leadership role.

As Alan Eisman stated:

“Emergency medicine sits at the intersection of prehospital demand, the evaluation and management of emergent and urgent patients, and one of the most consequential decisions in the acute care journey—whether to admit or discharge—with profound implications for patient outcomes, cost of care, and downstream hospital capacity.”



Emergency physicians influence diagnostic testing, treatment, and disposition, including whether patients are discharged, placed in observation, or admitted. Those decisions have significant implications for patient flow, capacity utilization, and outcomes.



Emergency medicine is the natural clinical and operational leader for ECAT improvement, but it cannot succeed alone. The problems ECAT exposes cross traditional departmental boundaries and require coordinated action across the patient journey.



Clinical and operational leaders direct the work, frontline teams execute it, and executive sponsors remove barriers.

7 | Create the Operating Cadence

A shared dashboard gives the tiger team a common view of ECAT performance, but each level of the organization needs different information. The reporting cadence, level of detail, and expected action should match the people reviewing the information.

At the tactical level, charge nurses, bed coordinators, ED attending physicians, hospitalist leads, and case managers need daily and weekly information they can act on quickly. That includes current boarding status, discharge targets, patients approaching ECAT thresholds, surge triggers, and patient-level outliers.

At the operational level, leaders from emergency medicine, hospital medicine, nursing, bed management, case management, quality, and analytics should meet monthly. They should review component-level performance, stratified outliers, recurring bottlenecks, and progress on current initiatives. These meetings also provide a place to escalate problems that require cross-departmental action.

At the strategic level, senior executives, medical directors, and the executive sponsor should review longer-term trends quarterly. Their focus should include performance against targets, reporting readiness, comparisons with relevant benchmarks, persistent capacity constraints, and decisions requiring additional resources or investment.



Plan-Do-Study-Act cycles support improvement across all three organizational levels. Frontline teams, supported by operational leaders, plan and test changes, study results, and decide next steps. Operational leaders coordinate and sustain improvement, while strategic leaders align priorities, provide resources and address barriers that cannot be resolved within individual departments.



Strategic Level

Who: CEO, CNO, CFO, CMO, ED Medical Director, HM Medical Director

- Agenda:**
- ECAT performance vs. targets
 - OPPS risk quantification
 - Capital investment decisions
 - Public reporting readiness
 - Avoidable Bed Days

Operational Level

Who: ED Director, HM Director, Nursing Director, Bed Management, Case Management, Quality/Analytics

- Agenda:**
- Component-level metrics review
 - Stratified outlier analysis
 - Bottleneck identification
 - Initiative tracking
 - Cross-departmental escalation

Tactical Level

Who: Charge Nurses, Bed Coordinators, ED Attending(s), Hospitalist Lead, Case Manager

- Agenda:**
- Real-time boarding status
 - Discharge targets
 - Surge escalation triggers
 - Patient-level outlier review
 - Predictive census

8

Measure Whether the Tail Is Actually Shrinking

The team needs to show that fewer patients are experiencing the problem it set out to address. The aggregate ECAT result is part of that assessment, but it should not be the only measure.

Tracking ECAT performance on a dashboard is essential because it brings patient access, throughput, quality, and patient experience measures into a shared operational picture. It helps identify variation early, maintain focus on safe and reliable care, and monitor trends over time.



Track these metrics:

- The count and failure rate for each ECAT component
- Encounters that fail more than one component
- Near-threshold encounters
- Upper percentiles
- How far delays extend beyond the threshold
- The patient groups, shifts, and locations most affected

Pair those results with a small set of balancing measures, such as safety, patient experience, workload, and downstream utilization, to ensure that improvement in one area has not created problems elsewhere.

Mark when each intervention began and document any changes to measure definitions, workflow documentation, timestamps, or source data. These changes can move a score without improving the patient experience.



The final test is whether fewer patients are experiencing the delays the team set out to fix. Track the targeted ECAT component and the tail around it, not only the aggregate score. Look for fewer failures, fewer near-threshold encounters, less severe delays, and improvement within the targeted patient population.

The goal for hospital organizations is measurable, sustainable improvement in access, flow, and patient care.



From ECAT Reporting to ECAT Management and Success

An ECAT score tells a hospital how many encounters met at least one failure criterion. It does not explain which patients were affected, what was happening at the time, or which process needs to change.

That work depends on data that can move from the composite result into the encounters, patient groups, shifts, locations, and system constraints behind it. The more closely the analysis reflects actual clinical workflows, the easier it becomes for teams to agree on the problem and decide where to intervene.





Where Hospital Leaders Planned to Begin

When attendees during the EDPMA webinar were asked, what they planned to do first, here's what they shared:

29%

planned to pull their current ECAT exposure data

24%

planned to schedule a meeting with hospital leadership

23%

planned to redesign how the metrics are reported internally

18%

said they needed to learn more before they knew where to begin

6%

planned to speak with a hospital medicine medical director

Percentages are rounded.

Those answers reflect different starting points, but the path forward is the same: establish a reliable baseline, identify where and why failures occur, align the right clinical and operational leaders, prioritize the highest-value opportunities, and measure whether change is actually improving care.

The eight steps in this playbook provide a practical framework for moving ECAT from a reporting requirement to an enterprise management discipline that can improve access, flow, capacity utilization, and outcomes.



Build a Focused **ECAT Improvement Plan**

ESO Emergency Care Throughput empowers emergency medicine and hospital leaders to identify the patients, shifts, and processes behind ECAT failures. Performance Advisory™ pairs that analysis with expert guidance to set priorities and develop a measurable improvement plan.

Talk With a Performance Advisor