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Improving Patient Flow in the Urgent Care Setting

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This Manuscript Partially Fulfills the Requirements for the

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Abstract

Practice Problem: Urgent care clinics provide care to patients with non-life-threatening illnesses or injuries and are found to be less expensive and more convenient than emergency departments. As urgent care clinics are growing in popularity so are the patient wait times and overall length of stay times.

PICOT: The PICOT question that guided this project was in urgent care clinic patients (P), how does utilizing the Emergency Severity Index (ESI) as a patient triage tool (I) compared to using no patient triage tool (C) affect the patient flow and patient wait times (O) within 13 weeks.

Evidence: Evidence search with applicable inclusion and exclusion material yielded six acceptable articles. The utilization of the Emergency Severity Index (ESI) triage tool decreased patient wait times and overall length of stay times leading to increased patient satisfaction.

Intervention: The ESI triage tool was implemented in the urgent care clinic so that patients were evaluated in a timely manner based on his or her ESI score. Patient wait times, length of stay times, and patient satisfaction scores were recorded.

Outcome: The overall results demonstrated that short length of stay times resulted in improved patient satisfaction scores. In addition, shortened patient to provider times resulted in higher patient satisfaction scores.

Conclusion: A significant impact was obtained in the urgent care clinic by implementing the use of the ESI triage tool. By utilizing the ESI triage tool, patient wait times and length of stay times decreased leading to improved patient satisfaction scores for the clinic.

Improving Patient Flow in the Urgent Care Setting

Urgent care clinics provide ambulatory emergent care for medical problems or injuries that are not considered life-threatening. The number of urgent care clinics continue to grow in the United States. Urgent care clinics are designed to provide effective, safe, and quality care to patients in a swift manner (Aungst, 2019). Many patients find visits at urgent care clinics to be less expensive and much more convenient than emergency department visits (Urgent Care Association, 2019). However, with the growing number of patients receiving care at urgent care clinics, wait times have increased. Lengthy wait times cause added stress to the patients and lead to poor patient satisfaction scores (Leddy et al., 2003).

Significance of the Practice Problem

The Institute of Medicine (IOM) developed a list of six aims to improve health care quality. The fourth aim is timeliness. The IOM believes lengthy wait times and harmful delays in care need to be addressed. Long wait times lead to increased mental stress to the patients and is evidenced by poor patient satisfaction scores. Therefore, patient wait times ultimately affect patient satisfaction (Leddy et al., 2003). At the urgent care clinic where the project plan was initiated, approximately 80-100 patients were evaluated every day. The clinic's patient satisfaction survey scores were ranged from one to five with five being excellent. With regards to patient wait times, the clinic's manager noted a significant increase in the number of patient satisfaction scores of two or less. Additionally, the wait time scores were low in 50 percent of the patients surveyed.

Often, patients correlate lengthy wait times to disorganization of the facility. If the patients perceive the health care provider or facility as not being well organized, most will seek care elsewhere. The urgent care clinic will be affected financially as patient numbers decrease

(Leddy et al., 2003). The urgent care clinic noted a correlation with the low satisfaction scores and decrease in revenue. The clinic's financial report noted an approximate \$5,500 decrease in revenue over the past three months.

There are approximately 7,500 urgent care clinics in the United States. Urgent care facilities "frequently experience long wait times, overcrowding, and patient dissatisfaction." (Aungst, 2019, p. 162). With increased use of urgent care facilities, patient flow needs to be improved. The Urgent Care Association reports at least 89 million visits to urgent care clinics occur each year (2019).

Like emergency departments, urgent care clinics do not utilize a scheduling system to create appointments. Patients are typically seen in the order in which they register at the front desk. In addition, it is difficult to predict the flow of patients and acuity of patients on any given day. Therefore, many urgent care clinics have difficulty evaluating patients in a quick and effective manner. The key to improving patient flow and wait times is improving the triage procedure (Aungst, 2019).

PICOT Question

In urgent care clinic patients (P), how does utilizing the Emergency Severity Index (ESI) as a patient triage tool (I) compared to using no patient triage tool (C) affect the patient flow and patient wait times (O) within 13 weeks.

Population

The population includes patients of all ages that present to the urgent care clinic for evaluation, assessment, and treatment of an acute illness or acute injury. All races, ethnicities, and genders will be included in the population.

Intervention

The intervention is the utilization of the ESI as the patient triage tool. The ESI is a five-level triage system that is commonly used in the United States (Worth et al., 2019). ESI assists in categorizing patients into five groups. Group one is considered the most emergent case while group five is the least emergent (Agency for Healthcare Research and Quality, 2020).

Comparison

The comparison is to not utilize any patient triage tool. Instead, the clinic would see patients on a first come first serve basis which is the current standard of practice at the urgent care clinic. All patients are seen in order of entrance into the clinic.

Outcome

The outcome will be that implementing a patient triage tool such as ESI will improve patient flow at the clinic. Ideally, improving patient flow will decrease patient wait times. Patient satisfaction scores will be higher with improved patient flow and decreased wait times. Patient satisfaction will be measured using patient satisfaction scores from patient surveys provided at the end of each clinic visit.

Timing

The expected outcome should be evident in approximately 13 weeks after initiation of the practice change.

Evidence-Based Practice Framework & Change Theory

The JHNEBP framework was utilized for the project. In the first phase for the project, the PICOT was identified, the interprofessional team was developed, the team leader identified, and the team meetings were scheduled. The second phase involved the evidence and utilized a five-step process. A thorough literature search for evidence was conducted for the project. The

evidence collected was evaluated using the tools provided by the JHNEBP framework. Only evidence from levels I through III was utilized for the project. In addition, the evidence for the project had to have a quality rating of *A* or *B*. The evidence-based change project was approved by the stakeholders of the setting to determine appropriateness. The plan was implemented, and the outcomes evaluated. A report based on the results was provided to all stakeholders and staff of the urgent care clinic after the evaluation was completed.

The change theory that served as the foundation for the project was Lippitt's model of change. Lippitt's change theory involved seven concise steps which were followed throughout the project. The seven steps included identifying the need for change, identifying the motivation to change, identifying resources, developing goals with the action plan, evaluating alternatives, initiating and maintaining the change, and stabilizing the change (Lippitt et al., 1958). For the project, a needs assessment was completed to identify the need for change and the motivation for change. A search was conducted to identify resources necessary for the change. Goals for the project included improved patient flow and patient wait times. The action plan included the utilization of the ESI triage tool. The evaluation of the alternative involved reviewing the patient wait times and patient flow without use of a triage tool which was currently being used at the clinic. The change was initiated in the clinic, and the change was maintained and stabilized by the clinic staff with assistance from the project manager.

Evidence Search Strategy

A literature search was conducted to support the PICOT question. The literature search assisted in identifying information regarding the topic (Harris et al., 2020). Databases used for the project's literature search included CINAHL, OVID, PubMed, Johanna Briggs Institute (JBI), and Google Scholar. Keywords utilized for the search in CINAHL, OVID, JBI, and

Google Scholar included *urgent care clinic*, *urgent care clinics*, *urgent care*, *urgent care setting*, *urgent care settings*, *emergency room*, *emergency rooms*, *ER*, *Emergency Severity Index*, *ESI*, *triage tool*, *triage tools*, *patient satisfaction*, *patient satisfaction score*, *patient satisfaction scores*, *wait times*, and *wait times*. Additionally, Boolean search structure was used with the operators *AND* and *OR*. An example of utilizing the Boolean search structure operators: (*urgent care clinic*) *OR* (*urgent care clinics*) *OR* (*urgent care*) *OR* (*urgent care setting*) *OR* (*urgent care settings*) *OR* (*emergency room*) *OR* (*emergency rooms*) *OR* (*ER*) *AND* (*Emergency Severity Index*) *OR* (*ESI*) *OR* (*triage tools*) *OR* (*triage tool*) *AND* (*patient satisfaction*) *OR* (*patient satisfaction score*) *OR* (*patient satisfaction scores*) *AND* (*wait times*) *OR* (*wait time*). With PubMed, MeSH headings were used and included *triage tools*, *patient satisfaction*, *wait times*, *emergency room* and *urgent care*. Specific search criteria were used as well. The search criteria consisted of English language, peer-reviewed articles, no data greater than 20 years old, and available abstracts. Data excluded from the search included if it pertains to a medical office setting other than urgent care. In addition, only data from the United States or Canada was included.

Evidence Search Results

The evidence search resulted in seven different articles to be utilized for the change project. The initial search yielded a total of 163 articles. CINAHL database provided 91 articles and PubMed provided 46 articles. In addition, OVID provided 26 articles. After implementing inclusion and exclusion criteria, the number of acceptable articles was decreased to seven. The inclusion criteria included being in the English language, peer-reviewed, conducted in the United States or Canada, and less than 20 years old. Exclusion criteria consisted of articles that pertained to medical office settings other than urgent care. The articles were decreased to seven

because many did not meet the inclusion criteria. In addition, several articles were found to be duplicates. A PRISM figure summarizing the search results is located in Figure 1.

Four of the five primary research evidence studies were quantitative. The remaining evidence study was qualitative. The evidence was labeled with its level of evidence and graded on the quality of the evidence presented based on the JHNEBP Model (Dang & Dearholt, 2017). Three of the five primary research evidence studies were labeled as Level II. The other two studies were labeled as Level V. For Level II, the evidence needs to be from a quasi-experimental study or random controlled trial. For Level V, the evidence is based on case reports or literature reviews. All five of the primary research evidence studies were provided with Grade B. Grade B is used when the study has reasonably consistent results, the sample size is adequate, and some control is evident. Additionally, two systematic reviews were included in the evidence search results. Both systematic reviews were labeled as Level I. Level I studies include random controlled trials and systematic reviews. Both systematic reviews were provided with a Grade A. To qualify as Grade A, the study must have consistent results, adequate sample size, and sufficient control. For more information regarding the studies included in the project, please refer to the evidence tables in Appendix A and Appendix B.

Themes with Practice Recommendations

There were themes noted within the evidence search including the use of triage tools, patient wait times, length of stay, number of patients leaving without being seen, and patient satisfaction scores. A total of six articles were found to be useful for this project.

Patient Satisfaction

Patient satisfaction was improved utilizing triage tools to determine priority of care that ultimately led to enhanced patient flow (Rodi et al., 2006). One study noted increased patient

satisfaction, decreased wait times, and decreased number of patients leaving without treatment (Daniels, 2007). Tlapa et al. (2020), a systematic review, demonstrated the same themes as the other evidence articles. Wait times were decreased while patient satisfaction scores increased.

ESI

The triage tool, ESI, was a vital resource to use for triaging patients presenting in the urgent care setting. Staff were provided the education and training to effectively and properly utilize the ESI triage tool (Theiling et al., 2020). Utilization of the tool accurately was of utmost importance to determine the level of care each patient requires. Daniels (2007) determined the utilization of a triage tool was essential. In another study, the ESI was used as the triage tool and found that the time to provider and overall length of stay were decreased (Gardner et al., 2018). Gardner et al. (2018), stated time to provider decreased by 15 minutes, the length of stay decreased by 34 minutes, and the number of patients leaving without being seen decreased (p. 125). Worth et al. (2019) noted that best practice is the use of ESI for triage.

Education/Training

Of the five primary research evidence articles and one systematic review article, all focused on patients presenting to an emergency room setting, fast track setting, or urgent care setting. Two of the six articles determined the importance of ESI education and training for nursing staff. In addition, a policy or procedure was needed to ensure triage nurses follow the guidelines of ESI when utilizing the tool for triaging patients. Education was necessary for the tool to be successfully utilized (Theiling et al., 2020). For ESI to be effective, nurses needed to be properly trained on the system, and the triage assessments monitored frequently (Worth et al., 2019).

Patient Improvements

Four of the six articles noted that with the utilization of ESI patient wait times decreased, length of stay decreased, patient to provider time decreased, and patient flow improved. These improvements led to improved patient satisfaction.

Summary Statement

The utilization of the ESI triage tool to effectively triage urgent care clinic patients enhanced patient flow by improving patient wait times, patient to provider times, and length of stay time compared to the standard method of evaluating patients in the order in which they presented to the clinic. In addition, the number of patients leaving the clinic before being evaluated was decreased with the use of the ESI tool compared to the standard method. With improved patient flow, patient satisfaction survey scores increased. Nursing staff needed to be educated and trained on how to conduct a triage assessment using the ESI triage tool. A policy and procedure were developed to provide the nursing staff with guidance.

Setting, Stakeholders, and Systems Change

The evidence-based change project occurred in a free-standing urgent care clinic setting. The typical participants were patients seeking emergency care for acute illnesses or injuries that were not life-threatening. On occasion, patients arrived at the clinic seeking care for chest pain or stroke symptoms. These patients were transferred to the local hospital for further assessment in the emergency department. Participants varied in age. A large portion of the population that utilized the clinic's services were college students and members of the Hispanic community. The clinic's healthcare providers included four nurse practitioners and two physicians. In addition, there were several radiology technicians, medical office assistants (MOAs), emergency medical technicians (EMTs), and nurses including registered nurses (RNs) and licensed practical nurses

(LPNs) working in the clinic daily. The clinic was open seven days a week. The mission of the clinic was to provide quality medical care to the community in a prompt, professional, and caring way. Additionally, the clinic strived to set a new standard in urgent care for the community the clinic serves. The vision of the clinic was to become recognized as a leader in urgent care. Compassion while demonstrating integrity and leadership were the values the clinic possesses.

A needs assessment was completed to determine the organizational need. SWOT analysis was utilized to identify the needs and capacity in the organization. See Appendix C for more details. Based on the needs assessment and SWOT analysis, patients were not satisfied with the overall patient flow at the clinic. Many patients felt that both the time to provider and time to discharge were lengthy. Several patients were noted to have left the clinic prior to being seen. An assessment of the organization was completed on numerous occasions. Disgruntled patients voicing their concerns about wait times were witnessed. In addition, a thorough review of the clinic's patient satisfaction scores and patient reviews from the last 12 months was completed. Patient satisfaction scores for wait times and patient flow were determined to be low.

The results of the needs assessment were provided to the clinic's office manager and clinic owner for review. At the same time, the project plan was presented. After discussing the results of the needs assessment and the project plan, the office manager and clinic owner agreed to the implementation of the project plan.

For sustainability, staff received frequent reminders via email and posters about the importance of continuing with the change plan. Compliance measures were collected by the office manager monthly. Monthly staff meetings were conducted to review the plan progress and to keep the staff informed of the satisfaction scores as scores were received. Interprofessional

collaboration between the front office staff, nursing staff, and healthcare providers was required for the project to be successful.

For the evidence-based change project, the stakeholders were identified. They included clinic patients, nursing staff, front office staff, clinic owner, clinic office manager, and healthcare providers. All stakeholders except clinic patients were involved in the stakeholder meetings. The nursing staff, front office staff, clinic owner, office manager, and healthcare providers were involved in initiating, maintaining, and evaluating the change. The clinic patients were involved in the change during their visit to the clinic.

The level of system change that the project created was meso-level because it involved the urgent care clinic as a group. The patient flow was changed from a first come first serve basis to a triage method using ESI. This process required the front office staff to notify the nursing staff when a patient arrived at the clinic. The triage nurse utilized the ESI tool to evaluate the level of urgency of the patient's condition. Patients with lower ESI acuity scores were seen first. To ensure this was done, the providers were notified of each patient's ESI acuity score. Ultimately, the entire organization was involved in the system change.

Implementation Plan with Timeline and Budget

Lippitt's change theory was utilized for implementation of the plan and to develop objectives of the plan. There were 5 objectives developed for the project plan.

1. The current policy and procedure for admitting patients at the clinic will be amended and patients will now be triaged utilizing the ESI tool. All patients will be seen based on the ESI acuity score they receive. Patients scoring three or lower will be seen first and may require immediate transport to a local hospital's emergency department for further evaluation. Patients with scores of four will be seen next. Lastly, patients with an ESI

acuity score of five will be seen. The ESI triage tool to be used is found in Appendix D. Providers will be notified of patient ESI scores to ensure that patients are assessed based on their scores.

2. The current policy and procedure for administering patient satisfaction surveys will be amended, and patients will now receive the survey prior to discharge. The discharge nurse will ask the patients to complete the survey prior to discharge and place the completed surveys into the secure box at the checkout counter. The surveys will be removed from the box every evening by the project manager. The completed surveys will be kept in a locked file cabinet for the duration of the project. The project manager will be the only person with the passcode to the secured file cabinet. The patient satisfaction survey is currently in use at the clinic. The project team reviewed the tool for face validity. The tool was found to be applicable to the project and easy to use. The data collection and evaluation methods were found to be reliable and dependable representation of the data. See Appendix E for a copy of the patient satisfaction survey.
3. Mandatory education on the new triage process will be provided to the clinic staff, including providers one week prior to the implementation of the project by the office manager. The education process will include a brief audiovisual presentation providing information on the ESI and the procedure for utilizing the tool in the clinic. The education will also include the new patient satisfaction survey that will be given to all clinic patients prior to discharge from the clinic. Additionally, posters detailing the triage process will be placed in the nurses' station and the staff breakroom.
4. A satisfaction survey will be developed and given to all clinic staff including providers to evaluate their thoughts on the new triage process. The staff and providers will be asked

to complete the survey at the end of each week from June 14, 2021, to September 15, 2021, and place the survey the secure box located at the checkout counter. The evaluation tool was developed by the project manager and reviewed for face validity by the project team. The tool is applicable to the project and easy to use. The data collection and evaluation methods were found to be reliable and dependable representation of the data. See Appendix F.

5. The ESI triage tool, new patient satisfaction survey, and staff survey will be implemented in the urgent care clinic beginning on June 14, 2021, at 0800. The project will conclude on September 15, 2021, at 1700. At the conclusion of the project implementation, the patient and staff satisfaction surveys will be evaluated and a conclusion regarding the project success or failure will be made.

The evidence from the literature search and review guided the practice change. In addition, following the guidelines from the JHNEBP framework directed the practice change. The schedule of activities using the JHNEBP framework were provided in Appendix G. The project implementation lasted for 13 weeks. The measures with goals for 30, 60, and 90 days were outlined in Appendix H.

There were resources that were needed for project implementation. Poster board was purchased to create poster presentations on the ESI triage tool and the new triage process. These posters were placed in the nurses' station and the staff breakroom. At least two cases of printer paper were purchased to print patient and staff surveys. The clinic needed to be reimbursed for the printer ink used to print surveys. Envelopes were purchased to provide with the patient and staff surveys. If they wished, the survey participants were able to secure their survey responses in the provided envelopes. A secure lockbox was purchased and placed at the checkout counter.

Only the project manager had access to the secure lockbox. Both staff and patient surveys were placed in the lockbox. To secure all the data received, a secure file cabinet was purchased and placed in the office manager's office for use by the project manager only and secured with a passcode. Data was entered into the project manager's computer. The computer had virus protection and was secured with a password. The computer was kept secure in the project manager's locked safe at home. During the timeframe of the project, the project expenses did not create an overage of the budget. Table 1 reviews the project budget.

The project manager as a leader was responsible for ensuring the project implementation team met the project objectives, followed the project guidelines, and followed the project timeline (Harris et al., 2020). The staff education was provided by the office manager. The project manager oversaw collecting the staff and patient surveys from the secure lockbox at the end of every clinic day and placed the completed surveys in the locked file cabinet. The clinic staff was able to meet with the project manager to voice any concerns during the implementation process. Potential risks included staff failing to document the necessary times in the medical record. Patients could have also refused or forgotten to complete or submit the patient satisfaction survey. Additionally, staff may have failed to submit the staff/provider satisfaction surveys. If these were not completed and submitted properly, the data collected would be skewed. For success of this project, the project manager was readily available to the staff and providers of the urgent care clinic.

Results

The approval process at the University of St. Augustine for Health Sciences required submission of the project proposal to the EPRC for evaluation. Once EPRC approval was obtained, facility approval was necessary. The project proposal was presented to the facility

management and approval was provided in the form of a letter on facility letterhead. After receiving both EPRC and facility approval, the project was implemented.

For the project, the patient flow was evaluated after implementing the ESI triage tool. Patients scoring a level one or level two on the ESI tool were excluded from the data collected. These patients were immediately transferred to the local hospital's emergency department. Patients of all ages presenting to the clinic with an ESI score of three or higher were included in the data collected. Wait time, defined as time from arrival to provider, was collected. Additionally, length of stay time, defined as time from arrival to discharge, was collected. The wait time and length of stay time were documented in the electronic medical record (EMR) for each patient. The time of arrival was documented in the EMR by the triage nurse along with the ESI score. The time the provider enters the patient's examination room was documented in the EMR by either the provider or the nurse working alongside the provider. At discharge, the time was documented in the EMR by the nurse providing the discharge instructions and patient satisfaction survey. The time data was collected by the project manager every two to three days, and the times were averaged for each day. If any of the times were not documented, the correlating patient visit was not included in the data collected. The patient satisfaction survey data was collected every two to three days as well and evaluated by the project manager. The patient satisfaction surveys, an internally created tool designed by the clinic management, remained anonymous and confidential. Finally, the staff satisfaction survey, designed internally by clinic management and the project manager, was utilized to determine the staff's opinion on the project. The staff surveys were collected weekly. The staff survey was also kept anonymous and confidential. In addition, both sets of surveys were kept in a locked file cabinet in the clinic manager's office. HIPAA regulations were followed. No patient identifiers were displayed with

the data. Regarding the data tools for the project, the ESI triage tool was free to use (Emergency Nurses Association, n.d.). The clinic's patient satisfaction survey tool was already currently in use at the clinic.

The evaluation design utilized was the logic model. The logic model is a planning tool that uses a visual aid to demonstrate the resources used for the project, the activities that will be completed, and the outcomes of the project (McCoy & Castner, 2020). Appendix I contains the project's logic model.

The wait times and length of stay times were organized into separate histograms. See Figure 2 and Figure 3. The patient satisfaction scores for wait times and length of stay times and overall triage process were organized into barplots. See Figures 4, 5, and 6. A boxplot was used to organize the wait times with the wait time patient satisfaction scores. In addition, another boxplot was used to organize the length of stay times with the patient satisfaction scores for length of stay time. The boxplots are in Figure 7 and Figure 8. To easily evaluate the staff survey results, barplots were created. See Figures 9, 10, 11, and 12.

For arrival to provider times, the patient satisfaction score of 1 Poor had an average of 61.26 minutes. The patient satisfaction score of 2 Fair had an average of 49.50 minutes. The patient satisfaction score of 3 Ok had an average arrival to provider time of 41.77 minutes. The patient satisfaction score of 4 Good had an average of 36.91 minutes. Finally, the patient satisfaction score of 5 Great had an average of 31.35 minutes. See Table 2 for further details. For length of stay times, the patient satisfaction score of 1 Poor had an average of 170.90 minutes. The patient satisfaction score of 2 Fair had an average of 146.28 minutes. The patient satisfaction score of 3 Ok had an average length of stay time of 122.50 minutes, The patient satisfaction score of 4 Good had an average of 90.20 minutes. Finally, the patient satisfaction score of 5

Great had an average of 69.80 minutes. See Table 3 for more details. The clinical significance of the project was to ultimately improve patient care and improve patient satisfaction. Long wait times can delay treatment causing physical harm to the patient (Leddy et al., 2003). Patients need to be evaluated by providers and interventions started in a timely manner to improve patients' overall outcomes.

The planned analysis of the evaluation data is further described in the table featured in Appendix H. A pre/post intervention change analysis was completed using a paired *t*-test with *p* values < 0.05 to validate that change occurred. The Intellectus Statistics software was utilized to enter statistical data and to develop statistical reports. The average daily arrival to provider time and average patient satisfaction score rating of 4 and 5 for wait times had a *p* value of < 0.001 . The average length of stay and average patient satisfaction score rating 4 and 5 for length of stay had a *p* value of < 0.001 . The statistical data indicated a change has occurred.

Impact

The evidence-based change project had a significant impact on the overall clinic, patients, staff, and providers. Patient wait times and patient length of stay times were decreased resulting in improved patient satisfaction according to the patient satisfaction surveys. Clinic staff and providers noted an improved working environment due to less patient complaints and agitation about long wait times. The ESI triage tool enabled patients to be triaged more effectively and in a timely manner. Patients meeting criteria for transfer to the local hospital were transferred quickly for more advanced care. In addition, the ESI triage tool allowed for a more organized patient flow through the clinic.

The future implications for the project as it continues beyond the implementation stage will be substantial. As more patients experience the new triage process, shortened wait times,

and improved length of stay times, the clinic could see an increase in clientele. There are other urgent care clinics in the area; however, none utilize the ESI triage tool. In addition, many of those clinics have very long patient wait times. Positive clinic reviews and patient satisfaction scores have increased which will ultimately impact the clinic by enhancing the clinic's financial status. It is anticipated the clinic's patient volume will increase in capacity due to improved throughput. There should be no limitations on maintaining sustainability of the intervention because all the providers, staff, and management of the clinic are in full support of the intervention.

Dissemination

The evidence-based change project was submitted to SOAR@USA after completing the necessary submission form. In addition, the project results were shared with the entire staff of the urgent care clinic including the providers and the office manager. An audiovisual presentation depicting the project outcome was provided. Copies of the data results were made available for the presentation attendees to review. The audiovisual presentation was also provided to the professional community including the nursing department at the University of Saint Augustine. The manuscript was submitted to the *Journal of Urgent Care Medicine* (JUCM). The JUCM is the official publication of the Urgent Care Association (UCA). The publication encompasses peer-reviewed articles and management articles and has a clientele of over 42,000 (Journal of Urgent Care Medicine, n.d.).

Conclusion

Implementing the ESI triage tool in the urgent care setting improved patient flow leading to improved patient satisfaction scores. The project plan was detailed throughout the proposal. The literature search outlined above provided evidence that ESI worked well as a triage tool to

improve patient flow and decrease patient wait times. To achieve the urgent care clinic's goal of providing the best medical care to their patients, patient flow needed to be improved.

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[UCA/Industry-News/ArtMID/10309/ArticleID/950/The-urgent-care-industry-trends-looking-to-fulfill-the-demand-of-a-growing-segment-in-the-healthcare-market](https://www.ucaoa.org/About-UCA/Industry-News/ArtMID/10309/ArticleID/950/The-urgent-care-industry-trends-looking-to-fulfill-the-demand-of-a-growing-segment-in-the-healthcare-market)

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Table 1*Budget*

EXPENSES		REVENUE	
Direct		Billing	0
Salary and benefits	0	Grants	0
Supplies (Posterboard, Copier supplies, Paper, Envelopes, Lockbox)	250.00	Institutional budget support	0
Services	0		
Indirect	0		
Overhead	0		
Gas Expense (project manager)	800.00		
Total Expenses	1050.00	Total Revenue	0
Net Balance			-1050.00

Table 2

*Summary Statistics Table for Interval and Ratio Variables by
Average_Overall_Length_of_Stay_Time_Pt_Satisfaction_Score*

Variable	<i>M</i>	<i>SD</i>	<i>n</i>	<i>SE_M</i>	Min	Max	Skewness
Average_Daily_Length_of_Stay_Min							
1 Poor	170.90	1.13	2	0.80	170.10	171.70	0.0
2 Fair	146.28	15.30	9	5.10	116.00	168.70	-0.5
3 Ok	112.50	15.23	38	2.47	79.20	144.50	-0.0
4 Good	90.20	13.32	46	1.96	63.00	120.00	0.1
5 Great	69.80	5.94	3	3.43	64.30	76.10	0.2

Note. '-' indicates the statistic is undefined due to constant data or an insufficient sample size.

Table 3

*Summary Statistics Table for Interval and Ratio Variables by
Average_Wait_Time_to_Provider_Pt_Satisfaction_Score*

Variable	<i>M</i>	<i>SD</i>	<i>n</i>	<i>SE_M</i>	Min	Max
Average_Daily_Arrival_to_Provider_Time_Minutes						
1 Poor	61.26	15.66	5	7.00	34.40	73.80
2 Fair	49.50	16.32	5	7.30	28.60	71.60
3 Ok	41.77	10.76	32	1.90	19.40	63.10
4 Good	36.91	8.96	45	1.33	21.10	64.90
5 Great	31.35	5.98	11	1.80	25.10	39.90

Note. '-' indicates the statistic is undefined due to constant data or an insufficient sample size.

Figure 1*PRISM Figure Summarizing Search Results*

Note. Reason 1: Conducted in location other than United States or Canada. Reason 2: Greater than 20 years old. Reason 3: Conducted in medical office setting other than urgent care. Adapted from: “The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews,” by M.J. Page, J.E. McKenzie, P.M. Bossuyt, I. Boutron, T.C. Hoffmann, C. D. Mulrow, L. Shamseer, J. M. Tetzlaff, E. A. Akl, S. E. Brennan, R. Chou, J. Glanville, J. M. Grimshaw, A. Hróbjartsson, M. M. Lalu, T. Li, E. W. Loder, E. Mayo-Wilson, S. McDonald...& D. Moher. *PLoS Medicine* 18(3): e1003583 (doi:10.1371/journal.pmed1000097). Copyright 2021 by The PRISMA Group.

Figure 2

Histogram of Average Daily Arrival to Provider Time Minutes

Figure 3

Figure 4

Figure 5

Barplot of Average Wait Time to Provider Pt Satisfaction Score

Figure 6

Barplot of Average Overall Length of Stay Time Pt Satisfaction Score

Figure 7

Boxplot of Average Daily Arrival to Provider Time Minutes by Average Wait Time to Provider Pt Satisfaction Score

Figure 8

Boxplot of Average Daily Length of Stay Min by Average Overall Length of Stay Time Pt Satisfaction Score

Figure 9

Figure 10

Figure 11

Figure 12

Barplot of Overall Satisfaction with New Process

Appendix A

Summary of Primary Research Evidence

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison (Definitions should include any specific research tools used along with reliability & validity)	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Worth, et al., 2019	Quantitative Level II Grade B	Sample: Licensed RN currently working in the ED Sample Size: 148	Intervention: ED Triage Structure and Process Survey created for data collection. Letter mailed to qualifying nurses with QR code to access survey also \$1 monetary incentive provided. Compared structure and process of triage nurse	Donabedian's Structure, Process, and Outcome Model	Outcome: Policy developed to identify triage nurse qualifications and will participate in triage system training. Policy developed to	Usefulness: Defined the Emergency Severity Index (ESI) thoroughly. Results: Majority of the Eds did not meet the requirements for the ESI system. Key Findings: Determined that a policy/procedure is needed to ensure triage

			qualifications, education, and triage decision making.		measure triage accuracy on a routine basis monthly.	nurses follow guidelines of ESI when utilizing the tool for triaging patients. Education is required for the tool to be effective.
Theiling, et al., 2020	Quantitative Level II Grade B	Sample: Visits to the ED from 2010-2015 from the National Hospital Ambulatory Medical Care Survey Sample Size: 805,726,000 ED Visits 553 Emergency Service Areas in	Intervention: Data reviewed and used included: chief complaint, vital signs, interventions, resources used, pain levels. Information utilized to divide into 5 acuity categories. Wait times also included	4-stage probability sample: geographic areas, nonfederal general hospitals, emergency services including outpatient clinics, random 4-	Outcome: Prioritizing care based on triage status, develop a tool with a policy/procedure for use to prioritize care, reduce wait times.	Usefulness: Discussed use of ESI throughout the nation and effectiveness of prioritizing care. Results: ESI can be an objective tool to measure a patient's complexity. Key Findings: Tool can be utilized to compare complexity of ED visits in various areas of the country over a specific period

		457 hospital systems		week reporting period.		
Rodi, et al., 2006)	Quantitative Level II Grade B	Initial Sample: 146 preintervention patients 115 postintervention patients 87 preintervention surveys completed, 91 postintervention surveys completed	Intervention: Fast track unit was developed as offset from main ED. Patients triaged as low acuity sent to fast track. Seen by physician assistant. Preintervention and postintervention surveys were created. 2 research technicians managed the preintervention surveys, ED technician managed the postintervention surveys.	Two anonymous surveys given with a time cycle analysis. Statistical data used in Fisher exact test and 2-sample t-test.	Outcome: Increased patient satisfaction with decreased length of stays or wait times.	Usefulness: Demonstrates use of acuity measurement for patients needing urgent care or fast track ED care Results: Patient satisfaction was improved utilizing triage tools to determine priority of care. Key Findings: Improving wait times improves patient satisfaction
Daniels, 2007	Qualitative Level V Grade B	Sample: 2 separate facilities	Intervention: 5-level triage system implemented. Patient satisfaction surveys	Case Study with clinical and	Outcome: 5-level triage system will be	Usefulness: defined and demonstrated use of 5-level triage system.

		<p>Facility A: 2321 Preintervention patients 2652 Postintervention patients</p> <p>Facility B: 2401 Preintervention patients 2552 Postintervention patients</p>	administered preintervention and postintervention.	operational metrics	<p>implemented. Policy/procedure to be created. Staff will be educated on properly using new system. Significant improvement in patient satisfaction with decreased wait times, length of stay</p>	<p>Results: Increased patient satisfaction, decreased wait times, decreased number of patients leaving without treatment. Key findings: establishing a triage policy/procedure is vital, staff will need to be educated on new policy for the new system to be effective</p>
Gardner, et al., 2018	Quantitative Level V Grade B	Sample: 120 patients seen by a nurse practitioner.	<p>Intervention: Pilot study conducted at an urban, university affiliated ED for 9 weekdays from 1100-2300. ESI tool utilized by triage nurse, triage NP or MD. Low</p>	<p>Pilot Study conducted. Statistical data evaluated in Mann</p>	<p>Outcome: ESI tool policy/procedure accepted utilized. Improved</p>	<p>Usefulness: Demonstrates the ESI tool being utilized to triage patients in urgent care/emergent situations. Results: Time to provider: decreased by 15 minutes,</p>

			acuity patients were sent to fast track/urgent care to be evaluated by NP.	Whitney U-test with p-value <0.01	patient satisfaction with decreased wait time and decreased length of stay times.	Length of stay decreased by 34 minutes. Number of patients leaving without being seen decreased. Key Findings: ESI tool improved various metrics in the facility
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Legend: ED, emergency department; ESI, emergency severity index

Appendix B

Summary of Systematic Reviews (SR)

Citation	Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/ Implications
Tlapa, Zepeda-Lugo, et al., 2020	Level II Grade: A	In ambulatory care, does Lean Healthcare interventions decrease patient wait times and length of stays?	Databases: PubMed, Cochrane Library, CINAHL, Web of Science, Scopus, EBSCO Strategy: Peer-reviewed, English, abstracts/full text, MeSH terms related to portions of the PICOT	Inclusion: January 2002-December 2018, English, Spanish, RCTs, quasi-RCTs, CBA studies, case-controlled, cohort, pre-post studies, healthcare settings with ambulatory care Exclusion: Outside of date mentioned above, cross-sectional studies, abstracts, surveys,	Two independent reviewers screened each study. Third reviewer used if needed when a decision could not be made. Data collected manually and tabulated using standard forms. Summary was	Length of Stay-19 of 22 noted a decrease Wait Time: 24 of 26 studies noted a decrease Patients leaving without being seen decreased in 9 of 12 studies. Patient satisfaction noted improvement	Usefulness: Reviewed many various studies on length of time, wait times, patient satisfaction, patients leaving without being seen in outpatient settings.

Citation	Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/ Implications
				simulations, opinion articles, studies focusing on interventions not related to healthcare or patient flow	generated. Meta- analyses could not be performed		Recommendation: Lean Healthcare interventions improve patient satisfaction, wait times in outpatient settings such as urgent care.

Legend: RCT, random controlled trial; CBA, cost-benefit analysis

Appendix C

Appendix D

A. Immediate life-saving intervention required: Airway, emergency medications, or other hemodynamic interventions (intravenous access, supplemental oxygen, monitor, electrocardiogram, or labs DO NOT COUNT); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, pulse oximetry (SpO_2) < 90%, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient who is either:

1. Nonverbal and not following commands (acuteley); or
2. Requires noxious stimulus (P or U on AVPU)

B. A high-risk situation is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of pain greater than or equal to 7 on a 0–10 pain scale.

C. Resources: Count the number of different types of resources, not the individual items (e.g., complete blood count, electrolytes, and coagulants equals one resource; complete blood count plus chest radiograph equals two resources.)

Resources

- Labs (blood, urine)
- Imaging
- Intravenous fluids (hydration)
- Intravenous, intramuscular, or nebulized medications
- Specialty consultation
- Simple procedure = 1 (laceration repair, foley catheter)
- Complex procedure = 2 (procedural sedation)

Not resources

- History and physical exam (including pelvic)
- Point-of-care testing
- Saline or heparin lock
- Oral medications
- Tetanus immunizations
- Prescription refills
- Contact with primary care physician
- Simple wound care (dressings, recheck)
- Crutches, splints, slings

D. Danger zone vitals: Consider uptriage to ESI 2 if any vital sign criterion is exceeded.

Pediatric fever considerations:

1–28 days of age: Assign at least ESI 2 if temperature > 38°C (100.4°F)

1–3 months: Consider assigning ESI 2 if temperature > 38°C (100.4°F)

3 months–3 years: Consider assigning ESI 3 if:

1. Temperature > 39°C (101.2°F); or
2. Incomplete immunizations; or
3. No obvious source of fever

Appendix E**Patient Satisfaction Survey**

We would like to know how you feel about your overall experience at the clinic today so that we can make sure we are meeting all your needs. Your responses will assist us in making improvements to the care our patients receive. All responses will be kept confidential and anonymous. Thank you.

Age	
Sex	
Race	

Circle how well you think we are doing in the following areas.	Great 5	Good 4	Ok 3	Fair 2	Poor 1
Clinic operating hours	5	4	3	2	1
Convenience of clinic location	5	4	3	2	1
Friendliness of front office staff	5	4	3	2	1
Triage process upon arrival to clinic	5	4	3	2	1
Wait time from arrival to provider	5	4	3	2	1
The provider and staff met my healthcare needs	5	4	3	2	1
My discharge instructions were explained to me. I was allowed time to ask questions.	5	4	3	2	1
Total length of stay time from arrival to discharge	5	4	3	2	1
Overall satisfaction with your clinic visit today	5	4	3	2	1

Comments:

Appendix F**Staff and Provider Satisfaction Survey**

Please complete the following survey regarding the new triage process with the ESI tool. The survey will need to be completed at the end of each week from June 14, 2021, to September 15, 2021. All responses will be kept confidential and anonymous. Thank you.

Circle the response that best identifies your feelings on each issue in the survey.	Great 5	Good 4	Ok 3	Fair 2	Poor 1
Triage process utilizing the ESI tool.	5	4	3	2	1
The ESI tool is easy to understand and use.	5	4	3	2	1
Patients seem more pleased with their wait times since starting the new process	5	4	3	2	1
Your overall satisfaction with the new triage process	5	4	3	2	1

Comments:

Appendix G

Project Schedule

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
Meet with preceptor	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Prepare project proposal	X	X	X	X	X	X	X	X																
Submit project proposal for approval								X	X															
Project approval obtained										X														
Review project with management of clinic										X														
Provide staff education for ESI triage tool										X														
ESI triage tool implemented at clinic											X													
ESI triage process continues at clinic												X	X	X	X	X	X							
Staff/providers complete weekly											X	X	X	X	X	X	X							

[illegible]

Appendix H

Evaluation Plan of improving patient flow in the urgent care setting by using the Emergency Severity Index													
Project Design: Pre-Post comparison of outcome, statistical & clinical evaluation													
Brief project description: completing the ESI tool on each patient entering clinic for evaluation, each patient will be seen based on his or her ESI score													
MEASURES	CATEGORIES						TIME for DATA COLLECTION						
Name & Metric (definition)													
	OUTCOME	PROCESS	BALANCING	FINANCIAL	SUSTAINABILITY	CONTEXT	Baseline	15 days	30 days	45 days	60 days	90 days	107 days
ESI level 3 patients will be seen first		X						X	X	X	X	X	X
ESI level 4 patients will be seen immediately following any level 3 patients.		X						X	X	X	X	X	X
ESI level 5 patients will be seen after all level 3 and level 4 patients have been seen that entered the clinic during the same time as the level 5.		X						X	X	X	X	X	X
Ensure all patient times are documented in the medical record from admission time to provider time to discharge time.			X					X	X	X	X	X	X
New protocol implemented for use of ESI tool to determine which order patients should be seen.					X								X
Ensure budget is being followed- review receipts from materials used				X			X	X	X	X	X	X	X
Patient wait times to provider will be decreased to < 15 minutes	X							X	X	X	X	X	X
Patient length of stay time from arrival to discharge will be <2 hours	X							X	X	X	X	X	X
Patient satisfaction scores will note scores of 5 or 4 for wait times and length of stay times	X							X	X	X	X	X	X
Patients presenting to the urgent care clinic from newborn to age 99 with ESI scores of 3-5						X	X	X	X	X	X	X	X

MEASURES	STATISTICAL TEST				Criteria	Define the	BASELINE	GOAL		
Name & Metric (definition)	paired t-test	unpaired t-test	χ^2	Other	State the p value or other criteria	Clinically meaningful criteria	Values	30 days	60 days	90 days
ESI level 3 patients will be seen first		X	X		<0.05	Patients currently have long wait times since the clinic sees patients on a first-come first-serve basis. Patients should be seen based on their medical need urgency	NA	>90%	>95%	>95%
ESI level 4 patients will be seen immediately following any level 3 patients.		X	X		<0.05		NA	>90%	>95%	>95%
ESI level 5 patients will be seen after all level 3 and level 4 patients have been seen that entered the clinic during the same time as the level 5.		X	X		<0.05		NA	>90%	>95%	>95%
Ensure all patient times are documented in the medical record from admission time to provider time to discharge time.			X		<0.05		NA	>95%	>95%	>95%
New protocol implemented for use of ESI tool to determine which order patients should be seen.			X		<0.05		NA	NA	NA	NA
Ensure budget is being followed-review receipts from materials used			X		<0.05		0%	>95%	>95%	>95%
Patient wait times to provider will be decreased to < 15 minutes		X	X		<0.5		0%	>90%	>95%	>95%
Patient length of stay time from arrival to discharge will be <2 hours		X	X		<0.5		0%	>90%	>95%	>95%
Patient satisfaction scores will note scores of 5 or 4 for wait times and length of stay times		X	X		<0.5		0%	>90%	>95%	>95%
Patients presenting to the urgent care clinic from newborn to age 99 with ESI scores of 3-5			X		<0.5		NA	NA	NA	NA

[illegible]

Appendix I**Logic Model**

	Inputs	Activities	Measures	Outcomes	Impact
Definition	Urgent Care Setting currently seeing patients on a first-come, first-serve basis	Interventions necessary for project implementation	Evidence interventions were performed planned	Measurable results from project	Implementation of a permanent change
Examples	Personnel: front office staff, nurses, EMTs, radiology technicians, providers	ESI triage tool upon arrival to clinic, recording admission time, provider time, intervention time, discharge time, calculating length of stay time (admission to discharge time), providing patients with patient satisfaction survey prior to discharge, instruct patients to complete survey prior to leaving clinic	Gathering time data from patient medical records at least every 2 days, collecting patient satisfaction surveys daily and keeping secure in a locked file cabinet in manager's office	Wait times will be decreased to 30 minutes or less, length of stay time will be decreased to <2 hours, patient satisfaction scores will be 5 or 4 regarding wait times and length of stay times	New policy/procedure implemented regarding the ESI triage tool.