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1 From Backcountry to Bedside: Training EM Residents in Decision-Making Under Pressure

Sarah Petelinsek, Ethan Grant, Theodore Hartridge, Rowan Kelner, Patrick Hughes

Objectives: This study evaluated whether outdoor experiential learning improves clinical decision-making education. We hypothesized that outdoor activities would enhance student awareness of decision-making processes and increase confidence in recognizing cognitive biases.

Methods: Emergency medicine (EM) residents at our institution were invited to participate in an outdoor experiential workshop. Prior to the workshop, residents completed a pre-course survey and selected one of three activities: advanced backcountry skiing, beginner backcountry skiing, or a backcountry rescue/snowshoeing activity. Residents were paired with trained backcountry guides and engaged in facilitated discussions on decision-making and bias recognition. Following the experience, participants completed a post-course survey assessing decision-making processes, overall workshop experience, and key takeaways. Pre- and post-course survey results were analyzed using a one-tailed two-sample unequal variance t-test. Data were reported as means and standard deviations.

Results: Of 36 eligible residents, 32 (89%) completed the pre-course survey and 20 (62.5%) completed the post-course survey. Participants reported high enjoyment (4.91 ± 0.30), increased bias awareness (4.52 ± 0.60), greater awareness of decision-making processes (4.48 ± 0.60), and perceived educational value (4.67 ± 0.48). Pre- and post-course comparisons showed significant increases in recognition of clinical/non-clinical decision-making parallels (mean increase 0.85, $P=0.001$), cognition around biases (mean increase 0.35, $P=0.02$), and understanding of biases (mean increase 0.30, $P=0.03$). Thematic analysis highlighted increased cognitive bias awareness, clinical application, teamwork, hands-on learning, and big-picture thinking.

Conclusion: Outdoor experiential learning is a feasible, novel, and well-received method for teaching clinical decision-making, significantly enhancing bias recognition and cognitive awareness.

2 Assessment of Gender Bias of Emergency Medicine Resident Physicians

Corinne Espinosa, Nileena Johnkutty, Courtney Knieriem, Alicia Rouff, Chiamaka Eneh, Amanita Setari, Gregory Neyman, Alyssa McQuillan, Skarleth Moran

Background: The perception of female physicians in

Emergency Medicine plays a crucial role in shaping the opportunities in a demanding medical specialty. Studies show female residents experience lack of mentorship and difficulties in establishing credibility. Initiatives have developed across residencies to promote diversity and we question whether they have been successful at implementing change.

Objectives: The purpose of this study is to assess the perception of gender bias within the emergency department, with an emphasis on female resident physicians.

Methods: A structured online, anonymous survey distributed to residents, advanced providers, and attending physicians involved in a 3-year emergency medicine program. They were asked to rate statements on a scale from 1-7 (1 is a strong disagreement and 7 is a strong agreement). Results were tabulated with counts, medians, IQRs, Mann Whitney U testing.

Results: Data from 48 participants, 50% identified as each gender and 56.3% are residents. The following questions were statistically significant in difference (p values 0.05-0.00007). Females were perceived more professional in behavior than men, men within the department can be patronizing to females ($p=.001$) and females opinions are overshadowed by males ($p=.0009$). Females felt co-workers perceived them as weaker members ($p=.003$) and males were seen as the leader in high stress situations ($p=.00007$). Females reported confidence was affected by how peers perceived them ($p=.007$), more gender bias ($p=.001$) and pushback from nursing $p=.003$). Only 24% report gender bias training.

Conclusion: Despite the emphasis on creating an inclusive environment, providers in emergency medicine still hold mixed perceptions of female emergency medicine physicians and data suggests female gender bias is present and may be a potential threat to female education. Further research is instrumental to determine steps necessary to create an equitable learning environment.

3 Patterns in Duration of Emergency Department Boarding and Variation by Sociodemographic Factors

Christiana K Prucnal MD, ScM, Melissa Meeker PhD, Martin Copenhaver PhD, Paul S. Jansson MD, MS, Rebecca E. Cash PhD, William Hillmann MD, Steven Knuesel MD, Wendy Macias-Konstantopoulos MD, MPH, MBA, Jonathan D. Sonis MD, MHCM

Background: Emergency department (ED) boarding negatively affects patient outcomes increasing length of stay, hallway care, and mortality. Prior research found disparities in capacity metrics like hallway care based on patient race/ethnicity, however whether boarding varies by sociodemographic factors is unclear.

Objectives: We examined whether duration of ED

boarding varied by sociodemographic factors in a hospital with a standardized bed prioritization process.

Methods: This single-center cohort study included all adult ED patients boarding after admission to the non-intensive care inpatient medicine service between February 2020 to February 2023 at an urban academic tertiary hospital with >110,000 annual ED visits. Primary outcome was time from admission order to inpatient bed transport. Patient demographics (age, sex, race/ethnicity, language, insurance, and housing status), visit characteristics (emergency severity index, time, and day), and bed request features (telemetry, sitter need, and active isolation precaution) were obtained via the medical record. We assessed bivariate relationships between boarding time and demographics with descriptive statistics and analysis of variance (ANOVA) using both adjusted and unadjusted regression analyses with generalized estimating equations (GEE) to account for patient level correlation.

Results: A total of 22,291 encounters were included. Average age was 64 (SD ± 19) years and 47% were female. Approximately 12% identified as Hispanic, 70% as non-Hispanic White, and 10% as non-Hispanic Black. Non-Hispanic Black-identifying patients boarded 19 minutes longer (95% CI -27.66, 65.26) and non-English primary language speakers boarded 20 minutes longer (95% CI -12.43, 51.82) than Hispanic-identifying patients and English primary language speakers respectively, although these findings were not statistically significant. Patients aged 65-years waited 46 minutes longer than younger patients (95% CI 19.05, 72.64, $p=0.001$), and those with Medicaid insurance waited an additional 52 minutes compared to those with commercial coverage (95% CI 18.14, 85.55, $p=0.003$).

Conclusion: Among adult patients admitted to medicine, advanced age and Medicaid insurance were significantly associated with longer ED boarding, whereas race/ethnicity and primary language were not. Further study should determine whether these findings are replicated in other settings, how this impacts patients, and if targeted intervention can reduce inequities.

4 GEDI - Geriatric service in the ED. Feel the Force

George Braitberg, Abdi Osman, Cilla Haywood

Background: Older adults account for a high proportion of Emergency Department (ED) presentations due to complex health needs. In 2023–24, people aged 65 and over represented 23% of all ED visits in Australia despite comprising only 16% of the population.

Methods: To address this demand, we introduced the Geriatric Emergency Department Innovation (GEDI) service in our tertiary ED (95,000 annual visits). GEDI provides

dedicated geriatric care, with a geriatrician present Monday to Friday (0900–1600) and weekends (0900–1230). From January 2023 to December 2024, GEDI assessed 3,232 patients (134 per month). Of these, 24.2% were admitted to an acute inpatient bed, 27.6% were discharged home or to their aged care facility, and 53.2% were admitted directly to geriatric or rehabilitation wards.

Results: To measure the impact of the service, we conducted an interrupted time series analysis using data from 1st August 2019 to 30th September 2023, covering pre- and post-GEDI periods. Our primary outcome was a reduction in acute inpatient admissions. Secondary outcomes included ED length of stay (EDLOS), admission rates, re-presentation rates, and Short Stay Unit (SSU) use. We analysed 53,020 pre-GEDI and 12,173 post-GEDI records. Overall, demographic characteristics were similar between the two time periods. Poisson and linear regression showed an increased monthly change in non-admissions post-GEDI (1.012; 95% CI: 1.004, 1.020) compared to pre-GEDI (1.001; 95% CI: 0.999, 1.002), with a median EDLOS reduction of -0.207 hours (95% CI: -0.344, -0.069).

Conclusion: The GEDI service reduced acute inpatient admissions and EDLOS. Future analyses will explore staff perceptions and cost-effectiveness.

5 Does Sharing Data On The Rate At Which Clinicians Work Alter Their Practice? A Study In A UK ED

Alexander Russell, Mark Harrison

Objectives: To assess whether sharing the number of patient's a clinician sees on average per shift with the clinicians in question increases the number of patient's they see per shift (hereafter called 'activity data') within a UK Emergency Department (ED).

To assess clinician perspectives on the sharing of such data.

Background: Several UK EDs are already sharing staff activity data with staff in an effort to drive up the rate at which clinicians see patients, but there is no published evidence that this is effective or of the impact of this upon clinicians.

Methods: A prospective quantitative and qualitative study looking at the number of patients seen per shift pre and post activity data being shared. Study took place from December 2024 to April 2025.

Quantitative analysis was done by weekly data supplied by the hospital's clinical information services on the number of patient's a clinician sees per shift – this was recorded by clinicians placing their name in the "seen by" column against a patient's name on the hospital electronic patient record system 'nervcentre'.

A 4-month period in which the same clinicians would be