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Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health

Title

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Permalink

<https://escholarship.org/uc/item/9dm8p9j4>

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 27(5)

ISSN

1936-900X

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Journal, WestJEM

Publication Date

2026-09-25

DOI

10.5811/westjem.66615

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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

in the department was chosen, with 2 months for baseline data collection, 1 month for data sharing and impact measurement and 1 month to see if activity returned to baseline to assess whether a Hawthorne Effect existed.

Qualitative analysis was done by means of an electronic survey sent to all ED clinicians. This was done with statements expressed on a Likert scale and some free text responses.

Results: Sharing activity data with clinicians increased the average number of patients seen per clinician per shift by 0.65 months between 2 and 3. This was a statistically significant change ($p=0.001$). Month 4 is currently ongoing to see if there is a return to baseline.

Survey results showed negative clinician perceptions on the sharing of activity data with the vast majority stating that it would have a negative impact on staff, with no change to the way or speed by which they work.

Conclusions: Sharing activity data with clinicians increases the number of patients that they see per shift on average. However, this is a modest increase relative to the potential negative impacts upon staff morale and working conditions.

Clinicians were of the perspective that knowledge of the data would not alter their practice, which conflicts with the reality which shows an increase in the number of patients seen on average per shift.

6 Expanding Stroke Screening for EMS Patients with Altered Mental Status: A Predictive Model Analysis

Joslyn Joseph, Gregory Neyman, Simcha Greenberg

Background: Stroke is a time-sensitive emergency in which early recognition and treatment significantly impact outcomes. Emergency Medical Services (EMS) play a vital role in early identification and hospital triage. EMS providers often determine transport destinations based on clinical impressions, protocols, and stroke center capabilities. Altered mental status (AMS) is a common reason EMS providers may miss acute ischemic strokes, but the value of performing stroke scales in all AMS patients remains unclear.

Objectives: This study assesses the utility of stroke screening in EMS patients with AMS by developing a predictive model based on stroke scale assessments and clinical factors.

Methods: We analyzed the 2022 National Emergency Medical Services Information System (NEMSIS) dataset, focusing on cases with AMS (ICD-10 code R41.82) as a primary or secondary symptom. Logistic regression models were applied to runs where a stroke scale was performed, incorporating demographics, vitals, response acuity, protocols, and symptoms. Two models—one for “Positive” and another for “Positive/Non-conclusive” stroke scales—were used to

estimate outcomes for AMS patients not screened.

Results: AMS accounted for 10% of EMS stroke impressions. Among 1,973,095 AMS runs, 407,556 (20.7%) included stroke scale assessments, with 19.1% positive and 21.2% non-conclusive. Strong predictors included hemiplegia (OR 14.67), stroke symptoms (OR 13.26), and speech disturbances (OR 5.58). The model estimated a 13.5% probability of a positive stroke scale in unscreened AMS patients.

Conclusion: Routine stroke scale use in AMS patients may enhance stroke detection and triage. Future studies should incorporate hospital-confirmed outcomes and explore barriers to EMS stroke scale use.

7 Current State of Emergency Department Boarding: A Call to Reimagine Resources to Meet Patient Needs

Christine Chien, Peter Vajda, Howard Klausner, Namita Jayaprakash, Seth Krupp, Mit Patel, Jo Ann Rammal, Victoria Al Karaki, Jennifer Stevenson, Steven Rockoff, Dmitry Davydov, Satheesh Gunaga, Jennifer Stephens-Hoyer, Solomon Knicely, Jason Vieder, Anthony Cruz, Gust Bills, Jacob Sinkoff, Megan Cahill, Heather Cronovich, Anthony Colucci, Brittany Betham

Background: Emergency Departments (EDs) are experiencing an unprecedented increase in boarding patients which is impacting the ability to provide efficient and safe patient care. While this issue is recognized in tertiary care hospitals, it remains less explored in community and freestanding EDs.

Objectives: The objective of this study is to explore the relationship between annual patient visits and patient hours of care provided in EDs. We hypothesize that despite decreasing annual patient visits, more hours of patient care are being provided.

Methods: The electronic health record (EHR) in a Michigan health care system with 9 Emergency Departments were analyzed for 2018 and 2023. These include: 1 tertiary care hospital, 4 community EDs and 4 free standing EDs. Metrics included Total Annual Patient Volume, Daily census, and daily Patient Hours of Care (PHC). A descriptive analysis was used to identify trends and differences when comparing 2023 to 2018, in these different types of EDs.

Results: For community EDs, total annual volumes decreased from 244,753 in 2018 to 228,896 in 2023, while PHC increased from 2,944 to 3,810. Freestanding EDs saw a slight decline in total annual volume, from 129,547 in 2018 to 128,156 in 2023, but daily PHC rose from 845 to 1,041. The tertiary care hospital ED experienced the most pronounced decline in total annual volume, from 101,210 in 2018 to 84,792, yet daily PHC significantly increased from 1,601 to