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Unscheduled care

August 2026

This monthly current awareness bulletin aims to highlight relevant reports and peer-reviewed literature in emergency and unscheduled care. The bulletin focuses on efforts to improve patient flow, reduce waiting times and alternative care models.

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References

Age UK. (2026) The longest wait to leave: tackling the delayed discharges that help to drive corridor care.

AlcazarPeral J.M., et al. (2026) 'Deployment of an Ambient AI Scribe in Emergency Care: A 12-Month Evaluation in a Large Spanish Hospital Network.' *International Journal of Medical Informatics 220*(pagination), Article Number: 106584. Date of Publication: 01 Nov 2026.
Background: Ambient artificial intelligence (AI) scribes have the potential to reduce documentation burden and improve efficiency, clinician experience, and care quality. However, evidence from large-scale implementations in emergency departments (EDs), particularly regarding patient experience and documentation quality, remains limited. We aimed here to evaluate the implementation of an ambient AI-powered scribe in EDs, assessing adoption, efficiency, transcription accuracy, clinician experience, patient experience, and medical report quality.
Method(s): We conducted a 12-month multicenter retrospective observational study (February 2025-January 2026) across five emergency specialties in 48 Spanish hospitals. All level 4 and 5 emergency consultations were included, with approximately 2.27 million emergency visits during the study period. We analyzed monthly adoption rates, consultation duration, transcription accuracy, patient experience measured by Net Promoter Score, clinician experience assessed through cross-sectional surveys, and documentation quality evaluated via structured audits.
Result(s): Scribe was used in 1,032,558 consultations (45.3 %), with monthly adoption increasing from 7.7 % to 57.8 %. A total of 2,097 physicians used Scribe at

least once, including 1,198 high-intensity users. Scribe-assisted consultations were significantly shorter ($p < 0.001$), with a mean relative time savings of 21.8 %. Transcription accuracy remained high and stable throughout the study (mean: 93.9 %). Audits of clinical reports showed higher documentation quality scores for Scribe-generated reports, with a large effect size and consistent improvements across physicians. Patient experience was significantly higher in Scribe-assisted consultations, and clinician experience was positive overall, particularly regarding workload, stress, and physician-patient interaction.
Conclusion(s): Implementation of an ambient AI scribe in emergency care was feasible, scalable, and associated with improved efficiency, higher patient experience, enhanced documentation quality, and positive clinician experience. These findings support the role of ambient AI scribes as a value-based health care intervention that simultaneously improves care quality, patient experience, and provider well-being.

Almunif T.M., et al. (2026) **'Early Recognition and Referral of Acute Stroke in Primary and Emergency Care: A Systematic Review.'** ***Western Journal of Emergency Medicine 27*****(3), 804–818.**
Introduction: Early recognition and referral are critical to minimizing morbidity and mortality in acute stroke, but evaluation and referral processes differ worldwide. In this systematic review we examined the accuracy of recognition tools, referral patterns, outcomes, and factors affecting efficiency in primary and emergency care settings.
Method(s): Following PRISMA 2020 guidelines, we searched PubMed, Scopus, Web of Science, and Cochrane Library for studies published January 2003-December 2025. Eligible studies included randomized controlled trials, cohort, case-control, cross-sectional, and large case series (> 30 patients) involving adults with acute ischemic or hemorrhagic stroke. Risk of bias was assessed using Cochrane Risk-of-Bias 2 (RoB) and RoB in non-standardized studies-I. We extracted data on diagnostic accuracy, referral pathways, outcomes, and systemic factors.
Result(s): We identified 206 papers, of which 33 studies met our inclusion criteria. Recognition tools such as Face, Arms, Speech, Time (FAST); Recognition of Stroke in the Emergency Room, the Cincinnati Prehospital Stroke Scale, and National Institutes of Health Stroke Scale showed good pooled sensitivity (79-95%) but variable specificity (52-84%). Newer technologies, including the PreHospital Ambulance Stroke Test, FAST-ED, and artificial intelligence (AI)-based models, showed promise but need validation. Referral strategies such as emergency medical services prenotification, dispatcher triage, and mobile stroke units reduced prehospital delays. Seven studies reported onset-to-door times 12-22 minutes faster and 7-12% increase in reperfusion eligibility. Increased referral efficiency was associated with a reduction in mortality of approximately 8-12% and improvements in functional independence of 10-15%, with persistent disparities reported in resource-limited settings.
Conclusion(s): Early recognition and referral improve outcomes in patients with acute stroke. Structured tools and system-level interventions reduce mortality, while AI and mobile stroke units show promise. Strengthening referral systems and adopting cost-effective triage strategies may support equitable implementation, particularly in low-resource settings, as addressing systemic and geographic barriers is critical for

equitable stroke care.

Altun M., et al. (2026) **'Reducing Emergency Department Crowding through a Transition Ward: A Pre-Post Observational Study.'** ***BMC Emergency Medicine 26*****(1) (pagination), Article Number: 183. Date of Publication: 01 Dec 2026.**

Background: Emergency department (ED) crowding is a persistent global issue, particularly in tertiary and university hospitals, where delayed admissions impair patient flow. This study aimed to evaluate the impact of implementing a transition ward (TW), established in May 2022 as a temporary inpatient care area to accommodate eligible admitted ED patients awaiting hospital beds, on ED crowding, focusing on reductions in boarding patient numbers and overall patient volume in ED.
Method(s): This prospective, observational, single-center study was conducted at the Adult ED of a tertiary hospital between April 23 and June 2, 2023. ED crowding data were collected six times per day, yielding a total of 216 data points. As a baseline reference, data from the identical period in 2021, before the implementation of the TW, were used for comparison. The primary outcomes were the number of boarding patients and the total number of ED patients. Secondary outcomes included the longest waiting time for admitted patients, and the longest waiting time for examination.
Result(s): Following the implementation of TW, the median total number of ED patients decreased by 22.0% (from 41.0 to 32.0; median difference -9.0, 95% CI: -10.4 to -7.7), and the median number of boarding patients decreased by 25.0% (from 23.5 to 18.0; median difference -5.5, 95% CI: -6.7 to -4.3). The median longest examination waiting time decreased by 40.2% (from 66.0 minutes to 39.5 minutes; median difference -26.5, 95% CI: -36.9 to -16.1).
Conclusion(s): The TW was associated with significant reductions in total ED patient volume and boarding patient volume, particularly in a high-volume tertiary care setting. These findings suggest that TWs can contribute to measurable improvements in ED patient flow and reductions in access block. Based on these positive outcomes, similar units may be extended to other inpatient specialties.

Bojesson A., et al. (2026) **'The ALLAN Trial: Impact of Early Home-Based Palliative Care on Emergency Care and Hospitalisation in Advanced Gastrointestinal Cancer Patients.'** ***British Journal of Cancer 135*****(2), 248–254.**

Background: Patients with advanced gastrointestinal (GI) cancer experience a high symptom burden which frequently necessitates emergency care. Integration of early home-based specialised palliative care (SPC) with tumour-specific treatments may impact emergency healthcare use.
Method(s): At the initiation of palliative chemotherapy, patients with advanced GI cancer were randomised to early home-based SPC integrated with tumour-specific treatment, or tumour-specific treatment with SPC referral when needed. The aim was to compare quality of life in the two groups. Here we present secondary outcomes; number of emergency department visits, hospitalisations, days of inpatient care, the time from the last chemotherapy treatment to death, and the place of death between the study groups.
Result(s): A total of 118 patients were randomised. Patients in the early SPC group had significantly fewer emergency department visits (median 1 versus 3),

hospitalisations (median 1 versus 2), and inpatient care days (median 1.5 vs. 11.5) compared to the control group ($p < 0.001$). There was no significant difference between the study groups in either time between the last chemotherapy treatment and death, inpatient SPC or place of death.
Conclusion(s): Early integration of home-based SPC in advanced GI cancer patients significantly reduces emergency healthcare use and hospitalisation. Clinical Trial Registration: ClinicalTrials.gov (ref: NCT02246725).

Cheng F., et al. (2026) **'Advancements in Smart Healthcare in Emergency Trauma Care: From Intelligent Triage to Prognostic Prediction.'** ***Frontiers in Public Health 14*****, 1834849.**
Emergency trauma care demands rapid, accurate decisions across the continuum from prehospital triage to definitive treatment and follow-up. Smart healthcare technologies, particularly artificial intelligence (AI) and telemedicine, are increasingly being integrated into trauma systems to augment clinical judgment, improve resource allocation, and expand access to specialist expertise. This mini-review synthesizes recent evidence on the application of these technologies in emergency trauma care. Current studies suggest that AI can support prehospital triage, identify life-threatening injuries on imaging, predict mortality, transfusion needs, and other adverse outcomes, and facilitate early risk stratification for both physiological and psychological sequelae. Telemedicine has shown value in remote consultation, transfer decision support, and virtual follow-up, with potential to reduce unnecessary interfacility transfers and optimize trauma system efficiency. However, the field remains constrained by major challenges, including the predominance of retrospective validation studies, limited prospective evidence of clinical utility, concerns regarding algorithmic opacity and bias, and persistent barriers related to workflow integration, infrastructure, reimbursement, and human factors. Overall, smart healthcare is reshaping emergency trauma care from intelligent triage to prognostic prediction, but its translation into routine practice will require prospective implementation studies, explainable and equitable model development, and closer alignment with real-world clinical workflows.

ColomaBazan E., et al. (2026) **'Clinical Outcomes and Predictors of Adverse Events in Influenza Patients Managed in a Hospital-at-Home Program: A 10-Year Retrospective Study.'** ***American Journal of Medicine Open 16*****(pagination), Article Number: 100135. Date of Publication: 01 Dec 2026.**
Background: Hospital-at-home (HaH) is increasingly used to manage acute conditions like influenza, but data on long-term outcomes remain limited.
Objective(s): To identify clinical predictors of 30- and 90-day adverse outcomes among influenza patients treated at HaH.
Method(s): We retrospectively analyzed 270 adult patients with laboratory-confirmed influenza managed at HaH over 10 influenza seasons. Outcomes included emergency room (ER) visits, hospital readmissions, and all-cause mortality at 30 and 90 days.
Result(s): At 30 days, 12.4% had ED visits, 5.1% were readmitted, and 3.4% died; at 90 days, these increased to 16.2%, 6.5%, and 6.8%, respectively. Multivariable analysis identified reduced glomerular filtration rate (GFR < 60 mL/min/1.73 m2) at discharge and early ER visits as independent predictors of poor outcomes.
Conclusion(s): Renal impairment and early postdischarge ER use are significant

predictors of adverse outcomes in influenza patients managed through HaH. These findings help clinicians optimize risk stratification and follow-up strategies during seasonal influenza peaks.

Curry E.N., et al. (2026) **'Comparison of Emergency Department Attendance After Emergency Care Recommendations from Nurse and Online eHealth Self-Triage.'** ***Telemedicine Journal and E-Health : The Official Journal of the American Telemedicine Association 32*****(7), 722–729.**
INTRODUCTION: Online self-triage is a newer eHealth modality, and there is a paucity of research on patient adherence to self-triage recommendations. We evaluated patient compliance with online self-triage guidance to seek emergency care and compared to nurse-triage adherence rates.
METHOD(S): We reviewed primary care empaneled patients who had either nurse phone triage or an online self-triage encounter that resulted in an emergency care recommendation between January 1, 2023, and November 30, 2024. Patients triaged for mood concerns, abdominal pain, chest pain, constipation, cough, and diarrhea were included. We reviewed whether patients had an emergency department visit within 24 h of their triage encounter. For self-triage encounters, we also examined whether patients called nurse triage within 24 h of their self-triage encounter.
RESULT(S): There were 689 self-triage and 2,385 nurse triage encounters with an emergency care endpoint. Adherence to the emergency care recommendation was substantially lower after self-triage (22%) than after nurse triage (61%). Patients who underwent nurse triage were significantly more likely to seek emergency care than those who self-triaged (odds ratio of 5.4 [95% CI: 4.5-6.6] $p < 0.001$). Both male and female patients were less likely to follow emergency care recommendations after self-triage compared to nurse triage ($p < 0.001$). There were 258 patients with an emergency care endpoint from self-triage who chose to call nurse triage (median time between encounters of 16 min). Only 78 (30.2%) also received an endpoint recommendation for emergency care, and 73% of those patients sought emergency care within 24 h.
DISCUSSION(S): Patient compliance with online self-triage recommendations to seek emergency care was poor and significantly less than nurse triage. Follow-up calls to nurse triage led to higher compliance. Health systems using online symptom checkers should consider employing mechanisms to follow up on emergency care recommendations. Further research should elucidate factors that contribute to patients' willingness to follow care recommendations.

Dean S., et al. (2026) **'Clinical Outcomes of Adults Accessing Acute Medical Same-Day Emergency Care in the NHS: A Retrospective Cohort Study Across Two Hospitals.'** ***BMJ Open 16*****(7) (pagination), Article Number: e121412. Date of Publication: 01 Jul 2026.**
Objectives: Same-day emergency care (SDEC) has been rolled out as a model of care in England with a limited evidence base. This study examined conversion to inpatient admission, 30-day reattendance and 30-day mortality, among adults managed through SDEC compared with those admitted for <=48 hours, as a proxy for low acuity, over a 4-year period, to assess safety and effectiveness in a real-world operational setting across two acute hospital sites.
Design(s): Retrospective cohort study.
Setting(s): Two acute hospital sites within one National Health Service (NHS) trust in

England, UK.
Participant(s): Adults aged >=18 years attending acute medical services between April 2021 and March 2025, managed via SDEC or admitted for <=48 hours (n=43 970). Outcome measures: Conversion to inpatient admission, 30-day reattendance and 30-day mortality.
Result(s): The crude conversion rate from SDEC to inpatient admission was 5.8%. In the multivariable model, increasing age (OR 1.02, 95% CI 1.01 to 1.02), male sex (OR 1.42, 95% CI 1.29 to 1.57) and attendance at the Boston site (OR 1.71, 95% CI 1.55 to 1.90) were associated with higher odds of admission.30-day prefix-concordant reattendance occurred in around 10% of patients in both pathways. After adjustment, SDEC patients had substantially lower odds of reattendance than those admitted for <=48 hours (OR 0.26, 95% CI 0.19 to 0.36). The effect of SDEC varied by age (interaction OR 1.02, 95% CI 1.01 to 1.02) and site, with a weaker protective effect at Lincoln compared with Boston (interaction OR 2.12, 95% CI 1.74 to 2.60). Age was associated with a reduction in reattendance (OR 0.99 per year increase, 95% CI 0.98 to 0.99).30-day mortality was lower in SDEC than in short-stay admission (0.6% vs 8.2%), with pathway remaining a strong predictor after adjustment (OR 0.05, 95% CI 0.04 to 0.07). Younger age was protective, while male sex was associated with higher mortality. Pathway by sex interaction indicated a less pronounced protective effect of SDEC in men.
Conclusion(s): SDEC was associated with very low conversion to inpatient admission and substantially better short-term outcomes than short-stay admission, including markedly reduced diagnosis-concordant reattendance and lower 30-day mortality. These findings indicate that SDEC is a safe and effective model for managing selected acute medical patients. The consistently favourable outcomes among SDEC attenders suggest that patient selection and operational factors within the emergency pathway may be directing lower-risk patients towards SDEC, highlighting the need to review how SDEC capacity is targeted to ensure alignment with its intended clinical role.

Gettel C.J., et al. (2026) 'Ambulatory Care Follow-Up and Fragmentation After Emergency Department Visits among Older Adults.' *Journal of Applied Gerontology 45*(8), 1625–1632.
Objectives: This study aimed to characterize ambulatory care patterns among older adults discharged from the emergency department (ED).
Method(s): This retrospective cohort study of 55,391 ED visits from the 2015-2021 Medicare Current Beneficiary Survey examined ambulatory follow-up within 7 and 30 days. Care fragmentation was assessed by identifying visits where patients saw 2+ different providers. Zero-inflated negative binomial models analyzed associations between patient characteristics (e.g., dementia, multiple chronic conditions) and follow-up.
Result(s): Follow-up occurred in 22.9% and 44.2% of cases within 7 and 30 days, respectively. Care fragmentation occurred in 4.6% and 25.3% of cases. Dementia

reduced follow-up odds (OR 0.74; 95% CI 0.66-0.84; p < 0.001), while multiple chronic conditions increased them (OR 1.27; 95% CI 1.19-1.36; p < 0.001).
Discussion(s): Most older adults lack timely ED follow-up, and care can be fragmented. These patterns highlight the need for interventions to balance access and fragmentation while improving outcomes.

Glober N., et al. (2026) **'A Novel Pilot Program using Patient Incentives to Address Emergency Department Boarding and Overcrowding: A Retrospective Observational Study.'** ***Academic Emergency Medicine 33*****(6) (pagination), Article Number: e70359. Date of Publication: 01 Jun 2026.**
Background: Emergency department (ED) overcrowding is a routine challenge for most hub hospitals, reported by more than 90% of ED medical directors several times each week. Alternate treatment locations are permissible within the Emergency Medical Treatment and Labor Act (EMTALA) regulations (with patient consent) as long as hospitals screen and stabilize any patient presenting to an ED.
Method(s): This pilot study explored the feasibility and patient acceptability of offering financial compensation to low-acuity patients who agreed to transfer from an overcrowded ED to critical access hospitals.
Result(s): Four eligible patients requiring medical-surgical admission participated. Transfers included travel vouchers of $300-$500. All transfers were completed safely without retransfer or complications, and all patients were discharged home. The aggregate Net Promoter Score was +75, indicating strong satisfaction.
Conclusion(s): Findings suggest that modest financial incentives may support patient-approved interfacility transfers, ease ED overcrowding, and enhance utilization of underused hospitals while complying with EMTALA. Further study of this model is warranted.

Jacques R.M., et al. (2026) **'Variation in Emergency Department Attendances and Acute Hospital Admissions for Ambulatory Emergency Care: A Retrospective Analysis of Routinely Collected NHS Data Across England.'** ***BMJ Open 16*****(6) (pagination), Article Number: e115446. Date of Publication: 01 Jun 2026.**
Objectives: Rising demand for emergency care in England is a continuing challenge driven by population ageing and increasing multimorbidity. Ambulatory emergency care (AEC) refers to the provision of same-day acute care for patients who might otherwise require admission. However, the contribution of AEC conditions to demand remains unclear. This study aimed to examine the proportion and nature of patients attending emergency departments (ED) with AEC-related conditions and to describe variation between hospitals in attendances and emergency admissions for AEC conditions. Design and setting: A retrospective study of routine data from 21 acute hospitals in England, including adult ED attendances and emergency admissions between 1 November 2021 and 31 October 2022. We used a federated approach to ensure data security, applying established AEC definitions to explore variation by age, socioeconomic status and length of stay. Outcome measures: Primary: Proportion of (i) ED attendances and (ii) emergency admissions for AEC conditions. Secondary: (i) Proportion of patients presenting at ED with an AEC condition who were admitted; (ii) proportion of emergency admissions with an AEC condition with a length of stay <2 days.
Result(s): We analysed 1 513 480 attendances (median per hospital: 73 125) and

660 105 admissions (median per hospital: 30 425). AEC accounted for 29.6% of attendances and 40.8% of admissions, with substantial inter-hospital variability. Patients aged >=65 were more likely to present with an AEC, while patients from deprived areas had lower rates. Among AEC-related admissions, 49.3% had a stay of less than 2 days.
Conclusion(s): Nearly one-third of attendances and two-fifths of admissions were for conditions potentially manageable in AEC or community settings. Variation between hospitals suggests local factors, including service configuration and primary care access, may influence avoidable acute care use. These findings suggest a need for a more nuanced understanding of the drivers behind AEC, or SDEC Services, to better understand their impact on reducing hospital admissions. Analysing these patterns may inform interventions to reduce avoidable hospital utilisation. Further research is needed to identify drivers of variation and to develop scalable strategies for prevention.

Johansson A., et al. (2026) 'Triage Effectiveness: A Framework for Quantifying the Effect of Emergency Triage Prioritization.' *BMC Medical Research Methodology 26*(1) (pagination), Date of Publication: 19 Jun 2026.
BACKGROUND: Emergency departments use triage to identify time-critical patients and reduce waiting times by assigning higher priority. However, no existing method directly measures this core clinical function. We developed and validated Triage Effectiveness (TE) as a framework for quantifying how well triage systems reduce waiting times for time-critical patients.
METHOD(S): Using data from 463,209 visits across eight emergency departments, we developed TE as a scale where 0% equals a first-come-first-serve strategy (no triage) and 100% equals perfect prioritization. The framework includes two complementary measures: 1. Waiting Time-based TE (WTE) measuring actual waiting time reduction, where 100% represents zero waiting time, and 2. Rank-based TE (RTE) measuring queue position improvement where 100% represents placement first in queue. Both can be calculated as theoretical TE (based only on priorities) and observed TE (actual clinical performance). We validated WTE and RTE calculations using analytical queueing models adapted for classification uncertainty and assessed transferability across hospitals.
RESULT(S): Queueing theory validation showed strong alignment with both WTE and RTE calculations, with RTE demonstrating greater robustness and less sensitivity to ED utilization patterns. TE increased with accuracy and produced negative values when triage performance was worse than chance. When applying the framework we found substantial gaps between theoretical and observed TE across all emergency departments, indicating significant post triage reprioritization.
CONCLUSION(S): The TE framework provides the first method for directly measuring the effectiveness of triage while utilizing full ordinal priority information. TE can assess the effectiveness of initial triage and the impact of post-triage re-

prioritization.

Khan, W. A. (2026) 'AI Versus Human-Led Triage in Primary Care and Emergency Settings: A Systematic Review and Meta-Analysis of Diagnostic Accuracy (2019-2026).' *Journal of Public Health and Community Medicine 5*(2), 173–176.

Aim/Background: Triage is a critical gateway in frontline healthcare, managing patient flow, and prioritizing clinical urgency. We evaluated the diagnostic accu-racy, operational efficiency, and safety of Artificial Intelligence-assisted triage sys-tems compared to traditional human-led triage across primary care and emergency settings.
Method(s): Following PRISMA 2020 guidelines and registered in PROSPERO, we systematically searched PubMed, Embase, and the Cochrane Library for studies published between January 2019 and January 2026. Two independent reviewers screened articles comparing AI triage (Large Language Models, neural networks, symptom checkers) against human clinicians. Risk of bias was assessed using the Quality Assessment of Diagnostic Accuracy Studies 2 tool. A bivariate random-ef-fects meta-analysis was performed to pool diagnostic accuracy metrics, with heterogeneity evaluated via the I^2 statistic and publication bias via Deeks' funnel plot.
Result(s): From 4,520 initial records, 20 core studies comprising 45,214 patient encounters were included. The pooled sensitivity for AI triage across all settings was 84.5% (95% CI: 79.2%-88.7%), with a specificity of 81.2% (95% CI: 75.4%-86.0%). Significant heterogeneity was observed (I^2 = 86%). Subgroup analysis revealed LLMs achieved higher sensitivity (88.1%) than rule-based symptom checkers (76.4%). A "safety paradox" was identified in high-acuity cases: advanced AI models exhibited a pooled under-triage rate of 12.0%, which was associated with adverse outcomes in emergency cohorts, compared to a 4.5% under-triage rate by human clinicians (p = 0.03).
Conclusion(s): AI-assisted triage demonstrates comparable accuracy to human clinicians for routine presentations but presents safety risks in high-acuity scenarios due to elevated under-triage rates. A "human-in-the-loop" implementation is essential to mitigate these risks and safely optimize operational throughput.

Larsen M.N., et al. (2026) 'Hybrid Hospital at Home and Physical Activity for Adults Admitted to the Hospital with Acute Illness: A Randomized Clinical Trial.' *JAMA Network Open 9*(6) (pagination), Article Number: e2618812. Date of Publication: 2026.

Importance Hospital-at-home (HaH) models may alleviate bed capacity constraints and reduce hospital-associated risks. Evidence on patient physical activity and patient experience in hybrid HaH for adults with acute conditions remains limited.
Objective To estimate whether a hybrid HaH model increases early physical activity and patient satisfaction without compromising safety or clinical outcomes compared with standard brick-and-mortar (BAM) care. Design, Setting, and Participants This single-center, investigator-initiated nonblinded randomized clinical trial was conducted at 2 internal medical wards at a regional public hospital providing acute and emergency care in Denmark. Enrollment was from June 1, 2023, to January 31, 2025; follow-up continued to May 20, 2025. Adults (aged >=18 years) admitted for acute illness were screened for eligibility. Key exclusions included unstable clinical

condition, major physical or cognitive impairment, limited Danish proficiency, and pregnancy. Interventions The hybrid HaH program (Influenzer) included remote patient monitoring via a patient-facing app and clinical dashboard with oversight 24 hours a day, 7 days a week; weekday virtual ward rounds; and home-based clinical tasks. BAM patients received standard inpatient care. Main Outcomes and Measures Coprimary outcomes were physical activity during the first 24 hours after randomization and patient-reported satisfaction and perceived safety shortly after discharge. Secondary outcomes included mortality (7, 30, and 90 days), readmissions (30 and 90 days), and adverse events of special interest during admission. Results Of 230 participants assessed for eligibility, 111 were randomized. The HaH model included 58 participants (median age, 64 [IQR, 50-75] years; 30 males [52%]); BAM included 53 participants (median age, 65 [IQR, 57-73] years; 28 males [53%]). HaH participants were significantly more physically active than BAM participants (adjusted mean difference, 1763 steps [95% CI, 153 to 3373 steps]; P =.03). Satisfaction was higher in HaH vs BAM (mean [SD] score, 4.41 [0.79] vs 4.10 [0.81]; mean difference, 0.31 [95% CI, -0.03 to 0.65]; P =.04), while perceived safety was similarly high across groups (mean [SD] score, HaH: 4.37 [0.88] vs BAM 4.23 [0.83]; mean difference, 0.14 [95% CI, -0.22 to 0.50]; P =.24). No significant differences were observed in any of the recorded safety events. Conclusions and Relevance In this randomized clinical trial of adults receiving medical care for acute conditions at home, hybrid HaH was associated with greater early physical activity and patient satisfaction, with no signal of excess harm compared with BAM care. Future multicenter studies should incorporate frailty measures and assess durability and linkage to clinical end points.

Lewis J., et al. (2026) **'Winter all Year Round in Urgent and Emergency Care: A Large Retrospective Analysis of Routinely Collected NHS Data Across England, 2021-2022.'** ***BMC Health Services Research 26*****(1) (pagination), Date of Publication: 04 Mar 2026.**
BACKGROUND: 'Winter pressures' in urgent and emergency care (UEC) are widely accepted but have had little empirical attention. Amidst annually increasing demand for UEC and reports of extreme strain during winter, we aimed to understand the extent and nature of seasonal demand by analysing routine data from Emergency Departments (ED) and acute Admitted Patient Care (APC) episodes across England.
METHOD(S): This was a retrospective observational analysis using data from 26 hospitals and 22 EDs between 2021-11-1 and 2022-10-31 comparing emergency attendances and acute admissions between winter (October-March) and summer (April-September). Main outcomes included ED waiting times, length of admissions, the number of investigations, treatments and procedures received, and whether the contact was considered avoidable. Using a novel 'federated' approach exploiting local relationships with data providers, regional researchers analysed local data and provided summary statistics and analysis results to the lead site. Aggregation of summary results established a picture of seasonal demand across the country, and an understanding of regional variation in seasonal trends.
RESULT(S): 1,549,205 ED attendances (775,810 winter; 50.1%) and 747,685 APC admissions (368,910 winter, 49.3%) were analysed. We found no systematic seasonal differences in the number or nature of presentations. While regional variation existed for many outcomes, no nationally consistent effect of winter was found for any measure.

CONCLUSION(S): Winter pressures in UEC may not be driven by large differences in the number, avoidability or acuity of ED attendances or APC admissions. Rather, UEC may be operating at or near to capacity all year, meaning small fluctuations in demand or in the complexity of presentations may cause significant strain on an over-burdened system. Focus on managing seasonal demand should be modified to address year-round pressure. Effective policy may require structural reconfiguration to better regulate demand.

Maneesha P., et al. (2026) **'Emergency-to-Admission Waiting Time: Understanding the Strategy to Improve Patient Satisfaction and Outcomes.'** ***Journal of Emergency Medicine, Trauma and Acute Care 2026*****(2) (pagination), Article Number: 22. Date of Publication: 01 Jan 2026.**
Introduction: Emergency Departments (EDs) serve as critical entry points for patients requiring urgent medical attention. However, delays in patient admission from the Emergency Room (ER) to inpatient units contribute to inefficiencies in hospital operations, increased ER congestion, and negative patient experiences. Addressing these challenges requires a systematic approach to identify the contributing factors and implement effective solutions to them.
Aim(s): To identify the factors contributing to delays in admission from the ER.
Objective(s): To evaluate and analyze the underlying factors causing delays in-patient admissions from the ER to ensure timely and efficient transfer to inpatient care. Methodology: This cross-sectional study was conducted in the Emergency Medicine Department of a Tertiary Care Facility in a semi-urban area, between December 1, 2023, and December 31, 2023. Yamane's formula was used to select a sample size of 332 patients. Data were collected through direct observation using a validated self-structured data collection sheet. A questionnaire survey was conducted among relevant ED staff to identify the major reasons for admission delays. Statistical analysis was conducted using the Statistical Package for Social Sciences (SPSS) trial, version 30, and the data analysis tool in Microsoft Excel.
Result(s): Most patients were aged >60 years (21.7%). Of these, 65% were triaged into the yellow category (priority 2). The mean ER-to-admission time was 6.01 +/- 3.7 hours (range <1 to 9.7 hours). The major contributors to delays were multiple cross-consultations (54%), laboratory and imaging turnaround time (TAT; 27%), patient transfer delays (11%), and administrative delays (8%).
Conclusion(s): Multiple cross-consultations and repeated investigations were the key contributors to prolonged ER TAT. Implementation of standardized protocols, improved interdepartmental communication, and better patient transfer processes reduces ER-to-admission time, thereby improving patient satisfaction and clinical outcomes.

Modesto Dos Santos J., et al. (2026) **'Venous Thromboembolism Risk Assessment in Hospital-at-Home Setting: A Prospective Cohort Study (the TROMBODOM Study).'** ***European Journal of Internal Medicine 149*****(pagination), Article Number: 106889. Date of Publication: 01 Jul 2026.**
Background Venous thromboembolism (VTE) is a significant cause of preventable mortality in hospitalized patients. While risk assessment models such as Padua and

IMPROVE-VTE scores have been validated in conventional hospitalization (CH), their applicability to hospital-at-home (HaH) remains uncertain. Objectives To evaluate thrombotic risk stratification in HaH by comparing the 90-day VTE incidence and mortality between HaH and CH and developing an HaH-specific VTE predictive model. Methods This prospective observational cohort study comprised 2062 patients (1689 HaH; 373 CH) admitted for acute medical illnesses between 2022 and 2024. Thrombotic risk was assessed using Padua and IMPROVE-VTE scores. Primary outcomes were 90-day VTE incidence and mortality. Predictors of VTE in HaH were identified using multivariable logistic regression and incorporated into a novel model (TROMBODOM). Results HaH patients were older (mean, 71.7 vs. 64.5 years, respectively) and more often admitted for infections (90.1% vs. 63.0%, respectively) and cardiorespiratory failure (36.6% vs. 25.7%, respectively). A larger proportion of patients in HaH were classified as high-risk based on Padua (75.1% vs. 52.0%, respectively) and IMPROVE-VTE (46.3% vs. 27.1%, respectively). Ninety-day VTE incidence was lower in HaH (1.2% vs. 3.5%, respectively; OR, 0.33; 95%CI, 0.16-0.67), whereas mortality was higher (15.8% vs. 9.9%, respectively; OR: 1.70, 95%CI: 1.18-2.44). Padua and IMPROVE-VTE scores showed modest discriminatory capacity (AUC: 0.65 and 0.75, respectively) in HaH. TROMBODOM achieved superior predictive performance (AUC: 0.86). Conclusions Padua and IMPROVE-VTE overestimated the thrombotic risk of HaH. The newly developed TROMBODOM model improved VTE risk stratification in HaH and requires external validation.

Nelson R.E., et al. (2026) 'The Impact of an Oncology Hospital at Home Program on Health Care Costs.' *Medical Care.Publish Ahead of Print* (pagination), Date of Publication: 22 Jun 2026.
Introduction: - Hospital-at-home is an initiative to move health care services that have traditionally been provided in a hospital setting to a patient's home. The objective of this study was to assess the impact of the oncology Huntsman at Home (HH) hospital-at-home program on health care costs from the health care system's perspective.
Method(s): - Using a difference-in-difference approach, we compared health care costs between 169 oncology patients enrolled in HH and 198 similar patients who would have been eligible for HH but lived outside the HH service area. Costs were measured from the health system perspective using an innovative cost-accounting tool. We constructed longitudinal datasets spanning the 2 patient-quarters before enrollment and the 2 patient-quarters following an acute episode. Outcomes were total direct medical costs of health care encounters as well as subcategories of cost, including facility, imaging, supplies, pharmacy, labs, and other. We ran fixed effects linear regression models to assess the impact of HH on health care cost outcomes.
Result(s): - We found that HH was associated with a statistically significant reduction in cost for the 6 months post-admission (total -$8, 337, P=0.012) and the first quarter post-admission (-$10, 516, P=0.009), with significant reductions in pharmacy, facility, and other costs. We also examined a subset of patients with gastrointestinal or gynecologic cancers as exemplars of patients at considerable risk for extended complications and found similar cost reductions 6 months (-$8006, P=0.006) and in the first quarter (-$10, 438, P=0.004).
Conclusion(s): - We found that an oncology hospital at home lowers health care

costs, particularly during the 3 months following a care episode.

NHS England. (2026) Model discharge pathway.

Oskvarek J.J., et al. (2026) 'Emergency Department Crowding in the Modern Era: A Systematic Review (2018-2025).' *Clinical and Experimental Emergency Medicine 13*(2), 119–139.
Objective This study systematically reviews the causes, effects, and potential solutions to emergency department (ED) crowding, with emphasis on challenges amplified by the COVID-19 pandemic. Methods Following PRISMA guidelines, we searched MEDLINE, CINAHL, and the Web of Science for peer reviewed studies published from January 1, 2018, to January 31, 2025, that investigated ED crowding. Studies were included if they evaluated crowding causes, consequences, or interventions, using metrics such as ED length of stay, boarding, or left without being seen. Four reviewers independently screened titles, abstracts, and full texts. Study quality was assessed using the SIGN critical appraisal tools. This review was registered in PROSPERO (No. CRD420251117676). Results Of 23,408 studies identified, 226 met inclusion criteria. Most studies were retrospective (83%) and of low (62%) or acceptable (35%) quality. Crowding was primarily driven by input (high patient volumes, limited primary care access), throughput (staffing shortages, laboratory and imaging delays), and output (boarding, late discharges) factors. Adverse effects included increased mortality, treatment delays, prolonged inpatient stays, higher rates of patients leaving without being seen, and reduced patient satisfaction. Effective strategies included provider-in-triage, nurse-initiated orders, and split-flow models. Output-focused interventions, such as active bed management and early discharge protocols, required system-wide coordination. The COVID-19 pandemic shifted patient volumes and led to innovative solutions such as drivethrough clinics and repurposed spaces to alleviate surges. Conclusion ED crowding is a persistent global issue with significant clinical and operational consequences. While promising interventions exist, high-quality evidence remains limited, underscoring the need for system-level and multifaceted solutions.

Paller J., et al. (2026) 'eHealth Literacy in Emergency Care: A Scoping Review.' *BMC Health Services Research 26*(1) (pagination), Date of Publication: 07 May 2026.
BACKGROUND: With the rise of online health information (OHI), eHealth literacy has become increasingly important. The e-health literacy framework (eHLF) categorizes key skills necessary for effective eHealth literacy. Patients' limited health literacy correlates with preventable, non-urgent emergency department (ED) visits, contributing to overcrowding, increased costs, and stress among healthcare professionals. However, the role of eHealth literacy in the ED remains unclear. Understanding its impact is essential to provide insight into overcrowding and internet use in the ED. This scoping review aimed to investigate eHealth literacy in emergency care.
METHOD(S): A scoping review was conducted following the guidelines of the Joanna Briggs Institute (JBI). An initial literature search was conducted in March 2024, followed by a systematic literature search in May 2024 using the databases PubMed, CINAHL, and Ovid, supplemented by Google Scholar, reference lists, and

library sources. Inclusion and exclusion criteria were defined based on the PCC mnemonic. After study selection, the studies were critically appraised by two researchers using JBI checklists. Data was extracted and presented both narratively and in tabular form.
RESULT(S): Nine studies were evaluated, and results were categorized as "individual", "interaction", and "system" based on the eHLF. The primary objectives were to examine internet use before ED visits and its correlations with anxiety and cyberchondria - excessive online searching leading to unfounded concerns about physical health. Findings showed widespread internet use for health-related information, though most did not use it to decide whether to visit the ED. Some studies found increased searching correlated with anxiety and cyberchondria. Other aspects included the effect on the doctor-patient relationship, trust, access and understandability of OHI.
CONCLUSION(S): Internet use before ED visits is common and access to digital services is widespread. Some studies link increased internet searches to higher cyberchondria and impacts on the doctor-patient relationship. However, gaps remain in tailored digital devices and understanding eHealth literacy's association with demographic factors. Both patients and healthcare providers in the ED require education on using OHI. Health professionals should acknowledge internet use before ED visits and discuss online findings with patients. Government guidelines and support programs should help users make informed health decisions.

Richard L., et al. (2026) 'Disparities in Delayed Discharge among Patients Experiencing Homelessness.' *JAMA Network Open 9*(7), e2623860.
Importance: Patients experiencing homelessness face particular barriers to hospital discharge, which may result in an alternate level of care (ALC) designation, a delayed discharge status describing patients occupying beds while not requiring the intensity of care provided in the hospital. Evidence quantifying disparities in ALC designation among patients with recent experience of homelessness relative to matched comparators is limited.
Objective(s): To compare ALC rates among hospitalized patients with a recent experience of homelessness and matched patients from neighborhoods with the lowest level of material resources.
Design, Setting, and Participant(s): This population-based matched cohort study was conducted in Ontario, Canada, among 51 377 hospital patients aged 16 years or older discharged from April 1, 2022, to March 31, 2024. Exposure: Patients with a recent experience of homelessness, classified using a validated definition using health administrative data. Unexposed patients from neighborhoods with the lowest level of material resources were matched 4:1 on age, sex, year and month of admission, health region, and Charlson Comorbidity Index.
Main Outcomes and Measures: ALC designation and duration of ALC. Weighted standardized differences and negative binomial models were used to assess significance of disparities.
Result(s): The study included 11 168 patients with a recent experience of homelessness (mean [SD] age, 48.5 [16.5] years; 7384 male [66.1%]) and 40 209 matched comparators (mean [SD] age, 49.6 [16.7] years; 25 561 male [63.6%]). Patients with a recent experience of homelessness had a more than 4-fold higher ALC designation rate (9.1% [1014 of 11 168] vs 2.0% [810 of 40 209]; weighted standardized difference = 0.32; rate ratio, 4.51 [95% CI, 4.11-4.95]). Health region-

level variation was substantial, ranging from 2.39 (95% CI, 1.40-4.01) times higher in the Central West region to 7.88 (95% CI, 5.21-12.11) times higher in the Central region. Among patients designated an ALC, those with a recent experience of homelessness had a significantly longer ALC stay duration (incidence rate ratio, 1.22 [95% CI, 1.09-1.37]; difference of margins, 4.7 days [95% CI, 2.1-7.4 days]) after adjusting for key demographic and clinical factors.
Conclusions and Relevance: In this cohort study of hospitalized patients in Ontario, Canada, recent experience of homelessness was significantly associated with higher rates of ALC designation and increased lengths of ALC stay, reflecting structural barriers to accessing safe discharge locations and gaps in transitional and postacute care. Regional differences suggest that local capacity and supports may mitigate or exacerbate challenges. Interventions such as medical respite and supportive housing are critical to reducing delayed discharge among patients experiencing homelessness and promoting equitable health system performance.

Samadian K.D., et al. (2026) **'Reducing Emergency Diagnostic Uncertainty with TRACE: Triage and Risk Assessment Via Cost Estimation.'** ***Western Journal of Emergency Medicine 27*****(2), 457–464.**
Introduction: Diagnostic uncertainty significantly impacts patient safety in emergency medicine, leading to missed diagnoses and severe harm. Current predictive models primarily emphasize diagnostic likelihood without explicitly addressing potential clinical harm from errors. We propose Triage and Risk Assessment via Cost Estimation (TRACE), a machine-learning framework that incorporates expected-value calculations, defined as the probability-weighted estimate of clinical harm, and patient similarity metrics to address both diagnostic accuracy and risk assessment.
Method(s): Using the Medical Information Mart for Intensive Care IV-Emergency Department dataset, we developed TRACE, comprising two modules: the expected value-powered triage index (TRACE-T), which calculates expected patient acuity from vital signs and chief complaints, and the patient similarity diagnosis engine (TRACE-Dx), which predicts diagnoses by identifying historically similar patients and weighing their outcomes by clinical harm. We assessed TRACE-T's predictive performance, our primary outcome, using decision trees, random forests, and Lasso (least absolute shrinkage and selection operator) regression. The TRACE-Dx predictions, our secondary outcome, were evaluated through string matching (comparing diagnostic text) and sentence embedding similarity (comparing diagnostic phrases).
Result(s): Our final analysis included a total of 2,501 patients from the dataset, due to requirements for diagnosis-string cleaning and computational demands of similarity calculations. Within this subset, TRACE-T significantly improved triage prediction accuracy, with the random forest classifier's accuracy increasing from 0.605 to 0.705 ($P = .04$) and demonstrating a notable reduction in root mean square error from 0.635 to 0.541 ($P < .001$). The decision tree model improved from 0.467 to 0.593 ($P = .78$) but did not reach statistical significance. The TRACE-Dx generated five expected value-ranked predicted diagnoses per encounter (12,505 predictions across 2,501 patients) and achieved average sentence embedding and string match similarities of 93.3% (95% CI, 92.7-94.0%) and 92.5% (95% CI, 90.7-94.3%), respectively, indicating strong alignment with actual outcomes.
Conclusion(s): Expected value-based clinical harm modeling with patient similarity scoring enhances triage accuracy and diagnostic prediction in emergency care. Triage and Risk Assessment via Cost Estimation provides interpretable, actionable

insights that could be incorporated into real-time clinical workflows as decision-support tools to reduce diagnostic uncertainty and improve patient outcomes.

SelvaMedrano D., et al. (2026) **'Evaluation of Nurse-Led Triage in the Emergency Department: A Retrospective Observational Study.'** ***Journal of Clinical Nursing 35*****(8), 3441–3451.**
AIM: To assess the quality of the Spanish Triage System performed by nurses according to the triage code assigned to each patient and to examine factors associated with the need for re-evaluation after completion of triage. DESIGN: Retrospective longitudinal observational study.
METHOD(S): A retrospective analysis was conducted of patients triaged in the emergency department between 2018 and 2023. Patients triaged by other healthcare professionals and those who did not receive a triage priority level were excluded.
RESULT(S): 493,211 episodes were analysed. Most were low/intermediate acuity (Level IV 65.4%, Level III 23.9%; Level I 0.1%). Mean time-to-first physician record entry increased as acuity decreased (38 min Level I vs. 81 min Level V), yet recorded time-target compliance was lowest in Levels I-II (23.8% and 14.7%). Re-evaluation occurred more often in high-acuity levels and was independently associated with older age, male sex, lower oxygen saturation and longer emergency department length of stay; compared with Level I, Levels II-III and lower adjusted odds of re-evaluation.
CONCLUSION(S): Nurse-led triage demonstrated coherent clinical and operational stratification; however, the lowest recorded time-target compliance in the sickest patients suggests a gap between immediate care and electronic documentation.
IMPLICATIONS FOR THE PROFESSION AND/OR PATIENT CARE: Streamline documentation workflows for high-acuity cases and use re-evaluation risk profiles to prioritize monitoring and escalation. IMPACT: Evidence on nurse-led Spanish Triage System performance and time-documentation quality is limited. Acuity and flow metrics showed expected gradients, but target-time compliance was lowest in Levels I-II; predictors of re-evaluation were also identified. Findings support emergency department nursing, quality improvement and potential benefits for patients attending emergency departments. REPORTING METHOD: STROBE guidelines. PATIENT OR PUBLIC CONTRIBUTION: This study did not include patient or public involvement in its design, conduct or reporting.

Souza L.L., et al. (2026) **'Artificial Intelligence in Emergency Department Triage: A Scoping Review.'** ***Plos One 21*****(6) (pagination), Article Number: e0352338. Date of Publication: 2026.**
Triage in emergency departments (ED) is a critical process for prioritizing care and ensuring clinical safety. However, current triage systems often exhibit vulnerabilities that compromise the efficiency and quality of healthcare delivery. Artificial Intelligence (AI) has emerged as a promising innovation to support decision-making and optimize patient flow in these high-pressure environments. To map the available evidence regarding the implementation and performance of artificial intelligence in emergency department triage. This scoping review followed the Joanna Briggs Institute (JBI) methodology and the PRISMA-ScR guidelines. A comprehensive search was conducted across 13 databases (CINAHL, Cochrane Library, PubMed

Central, SciELO, Web of Science, SCOPUS, Science Direct, VHL, Embase, and several regional dissertation repositories), with no language or time restrictions. Two independent reviewers performed the selection process using the Rayyan platform, with discrepancies resolved by a third evaluator. Data were synthesized using the PAGER framework, categorizing findings into Patterns, Advances, Gaps, Evidence for practice, and Recommendations for research. Nineteen studies met the inclusion criteria. AI was primarily implemented through Machine Learning (ML) algorithms, including Deep Learning architectures. Natural Language Processing (NLP) was frequently employed to process unstructured clinical data, with recent studies exploring the potential of Large Language Models (LLMs). Overall, ML-based models consistently outperformed traditional triage systems in predictive accuracy. These techniques were mainly utilized for automated classification, predicting clinical severity, and enhancing patient prioritization by integrating both objective and subjective assessment data. The findings indicate that AI has significant potential to enhance emergency triage by streamlining service flows and providing robust clinical decision support. However, the current evidence remains heterogeneous and largely exploratory. Key challenges include variability in model performance, a lack of external validation, and studies often limited to specific populations. Consequently, many current tools still lack the necessary reliability for safe, large-scale clinical implementation.

Sumartini S., et al. (2026) 'Building Resilience in Emergency Care Teams: A Narrative Review of Team-Based and Organisational Strategies for Nurses and Allied Health Professionals.' *Journal of Multidisciplinary Healthcare 19*(pagination), Article Number: 609206. Date of Publication: 2026.
Background: Emergency department (ED) nurses and allied health professionals (AHPs) face persistent occupational stressors that threaten workforce sustainability. Burnout prevalence exceeds 50% among ED nurses, and post-traumatic stress disorder (PTSD) prevalence among paramedics ranges from 11% to 37%. Despite growing research interest, the team-based and organisational resilience-enhancement strategies targeting both ED nurses and AHPs have not been comprehensively reviewed.
Objective(s): This narrative review synthesises current evidence on team-based and organisational resilience-enhancement strategies targeting ED nurses and AHPs in emergency and acute care settings globally.
Method(s): A systematic search informed by JBI scoping methodology and reported in line with PRISMA 2020 was conducted across three databases (Scopus, PubMed, Web of Science) for studies published between January 2016 and March 2026. Search terms combined three concept blocks-emergency care personnel (eg, "emergency nurs*", "paramedic*", "allied health professional*"), resilience constructs (eg, "resilien*", "coping", "hardiness", "post-traumatic growth"), and emergency/acute care context (eg, "emergency department*", "prehospital", "ambulance service*")-using Boolean operators. The Population-Concept-Context (PCC) framework guided eligibility. Studies scoring >=70% on JBI critical appraisal checklists were included; a sensitivity analysis examined the effect of relaxing this threshold to >=50%. Data were charted using a standardised JBI extraction form and synthesised narratively.

Result(s): From 766 identified records, 160 duplicates were removed, 606 titles/abstracts were screened, and 196 full texts were assessed. Forty-nine empirical studies met the inclusion criteria; one record initially retrieved was a registered trial protocol with no outcome data and was excluded from synthesis. Of the 49 studies, 32 (65.3%) focused on ED nurses, 12 (24.5%) on AHPs/paramedics, and 5 (10.2%) on mixed teams. Five intervention categories were identified: organisational support (n=17, 34.7%), system-level reforms (n=12, 24.5%), structured training programmes (n=11, 22.4%), peer/team-based support (n=7, 14.3%), and leadership development (n=2, 4.1%). Controlled intervention studies reported positive effects: a three-arm randomised controlled trial (RCT) demonstrated significant improvement in psychological resilience ($p<0.05$), and a violence-coping programme produced a large effect on resilience ($F=59.41$, $p<0.001$). The Cochrane meta-analysis included reported a moderate pooled effect on resilience (standardised mean difference [SMD]=0.45) and stress (SMD=-0.61). Cross-sectional studies reported moderate-to-strong associations between perceived organisational support and resilience (eg, $r=0.549$).
Conclusion(s): This narrative review identified five intervention categories addressing resilience in emergency care teams, with organisational support and system-level reforms most frequently reported. Controlled studies, although few, consistently reported positive effects. Critical gaps exist in leadership-focused strategies (4.1%) and AHP-specific research (24.5%). Future studies should prioritise longitudinal designs, standardised resilience outcome measures, and culturally adapted interventions.

Vardy E.R.L.C., and Masoli, J. A. H. (2026) 'Hospital at Home-what does the Evidence Tell Us?.' *Age and Ageing 55*(7) (pagination), Article Number: afag208. Date of Publication: 01 Jul 2026.
Hospital at Home (HaH) has emerged internationally as an effective model of healthcare delivery for older adults, providing care within patients' homes as an alternative to inpatient admission when appropriate. Since the COVID-19 pandemic, there has been rapid expansion of HaH services, of which older people are the majority users. This collection in Age and Ageing journal brings together contemporary evidence examining the evolution, effectiveness, implementation and experience of HaH care for older people. The papers highlight the heterogeneity of HaH models, ranging from admission avoidance and early supported discharge services to comprehensive geriatric assessment-based multidisciplinary care. Collectively, the evidence suggests that well-supported HaH models can achieve outcomes comparable to inpatient care, with evidence supporting cost-effectiveness and reduced care home admission, whilst improving patient experience and increasing time spent living at home. Importantly, the collection also explores the complexities underlying HaH implementation. Several papers demonstrate that successful HaH depends not only on technology, but on multidisciplinary clinical expertise, coordination across services and substantial contributions from informal caregivers. Challenges relating to workforce capacity, digital exclusion, caregiver burden and service integration remain significant.

Zheng H., et al. (2026) 'Hospital Closures Increase Emergency Care Travel Time: Rural-Urban Disparities.' *Inquiry : A Journal of Medical Care Organization, Provision and Financing 63*, 469580261454514.
Travel time is a key factor for emergency care access and outcome, especially in traumatic or time-sensitive injuries. Hospital closures can lead to the shutdown of the emergency departments (EDs), which cut emergency care service for the population they previously served. This study aimed to evaluate how hospital closures were associated with likelihood and magnitude of travel time increase to emergency departments in Texas by Rural-Urban Commuting Area (RUCA) categories (Metropolitan, Micropolitan, Small Town and Rural). We obtained the 2023 list of licensed Texas hospitals and identified hospital closures back to 2012. Travel time and distance to the nearest and second nearest emergency departments were calculated by ArcGIS Pro 3.2 and the Network Analysis extension based on 2020 U.S. Census. We used logistic and OLS regressions with geographic categories, baseline travel time, and socioeconomics covariates at the census tract level. Among a total of 6,883 census tracts, 135 experienced travel time increase to the nearest ED and 263 to the second nearest ED. Compared with Metropolitan areas, Micropolitan, Small Town and Rural areas have a higher predicted probability of experiencing travel time increase. Among affected census tracts, travel time increased by 3.83 minutes in Micropolitan area, 5.04 minutes in Small Town area, and 2.67 minutes in Rural area to the nearest ED compared with Metropolitan area (statistically significant except Rural). Compared with Metropolitan area, traveling to the second nearest ED increased 2.43, 4.60 and 1.95 minutes, respectively (all statistically significant). Our findings suggest that hospital closures have a disproportionate burden on rural communities than urban communities.

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