Old Dominion University

ODU Digital Commons

Emergency Departments and Care for Marginalized Populations

Irvin B. Harrell
Old Dominion University, iharell@odu.edu

Recommended Citation

EMERGENCY DEPARTMENTS AND CARE FOR MARGINALIZED POPULATIONS

by

Irvin B. Harrell
B.S. Journalism 1989, University of Florida

A Thesis Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
Requirements of the Degree of

MASTER OF ARTS

HUMANITIES

OLD DOMINION UNIVERSITY
May 2019

Approved by:

Michael Allen (Director)

Muge Akpinar-Elci (Member)

Rob Cramer (Member)

ABSTRACT

EMERGENCY DEPARTMENTS AND CARE FOR MARGINALIZED POPULATIONS

Irvin B. Harrell
Old Dominion University, 2019
Director: Dr. Michael J. Allen

Healthcare providers in emergency departments (EDs) face a daunting daily task: providing health care in a triage setting to a diverse group of patients many with complex medical issues. Many patients rely on ED services out of financial necessity, when their healthcare issues could be better suited for care from a primary care physician. Many of these already vulnerable patients – minorities, those health illiterate, low-income, uninsured and those with language barriers – must also deal with ED overcrowding and staffing conditions. In some cases, patients leave without being seen while others face bed shortages. This study explores healthcare provider experiences and highlights some of the challenges of health care in the ED. This study also provides insight into possible interventions designed to better address the needs of ED patients. Through the use of a questionnaire, this study relays the experiences of 27 professionals who have worked in EDs the Hampton Roads area. While heart attacks, breathing problems, and trauma comprise the most common diagnoses and treatments cited by questionnaire respondents, this study found that overcrowding, long wait times, and staffing shortages were the biggest challenges that regional ED staffs faced. Caregivers surveyed in the study suggested that increased staffing, more beds, better transportation and more diligence in following up with patients could improve conditions in emergency departments.

This thesis is dedicated to the many without a voice, without a means to be more proactive in their personal healthcare, as well as healthcare providers who despite limited resources work their hardest to ensure health equity for those less fortunate. This thesis is also dedicated to my father and mother, Rudolph and Emma Gray, who taught me the importance of helping those who sometimes don't have the means to help themselves. They also taught me the importance of education – how it opens your mind to infinite possibilities, and how you can take the knowledge you possess and work as a change agent for others.

ACKNOWLEDGMENTS

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF GRAPHS

CHAPTER I

INTRODUCTION

Systemic issues plague certain populations and hinder their ability to obtain high-quality health care. Affordable health care, access to health care, and the lack of health insurance are but a few of these issues. For example, from 2013 to 2015 the percentage of uninsured adults aged 18-64 living in or near poverty decreased, yet 26.2 percent of poor and 23.9 percent of near-poor remained uninsured in 2015 (Centers for Disease Control and Prevention [CDC], 2015). Ample research has determined that not only can socioeconomic status affect an individual's treatment options and health outcomes, but characteristics such as your ethnicity and health literacy also can be factors (Hong et al., 2007; James et al., 2005; Jordan et al., 2010). When healthcare options are limited, those seeking help often turn to emergency departments (EDs) and emergency rooms (ERs), where they can be guaranteed care regardless of financial shortcomings.

According to the 2015 National Hospital Ambulatory Medical Care Survey, there were 43.3 ED visits per 100 persons, and 1.5 million ED "visits resulting in admission to a critical care unit" (CDC, 2015). EDs serve everyone – often becoming a melting pot for different segments of society regardless of health condition or economic status. Tackling this diverse population each day is no easy job for ED staffs who continue to work on better assisting their patients. This research intends to provide insight into the experiences of healthcare professionals who work in EDs as well as brainstorm possible interventions to help caregivers' better serve patients in these facilities.

PURPOSE

Components of good health care are not only access to care, but also ensuring that patients have a clear understanding of policies, procedures, and prescriptions through effective communication. Preventive care and ambulatory care play key roles in proper health care. Preventive care means having regular checkups to catch potential health problems before minor problems escalate. This type of care can involve tests for blood pressure, diabetes, and cholesterol; mammograms and colonoscopies to check for cancer; and counseling to help people quit smoking, lose weight, eat healthy, or cut back on alcohol consumption (U.S. Department of Health & Human Services [HHS], 2018). Ambulatory care includes those clinical, organizational, and professional activities engaged in by registered nurses with and for individuals, groups, and populations who seek assistance with improving health and/or seek care for health-related problems. Thus, ambulatory care nursing "is characterized by rapid, focused assessments of patients, long-term nurse/patient/family relationships, and teaching and translating prescriptions for care into doable activities for patients and their caregivers" (American Academy of Ambulatory Care Nursing [AACN], 2018). This type of care typically happens when patients have both health insurance and primary care physicians.

However, the nation's EDs are heavily relied upon by those with few healthcare options in the United States. In these facilities, patients find sanctuary when obtaining treatment because of their socioeconomic status, their lack of insurance, or other factors. Individuals who often depend on the ED include minorities, people with language barriers, and the health illiterate (Fields et al., 2016; Kosoko-Lasaki et al., 2009; Sonnenfeld et al., 2012). In 2015, 136.9 million visitations occurred to EDs; 13.3 million of these visits were by those without health insurance (CDC, 2015). Some ED patients arrive in desperation and as a last resort. Many are homeless,

have mental health issues, are young, and are elderly (National Hospital Ambulatory Medical Care Surveys [NHAMCS], 2005). But they all need care and are forced to find it in a triaged setting – where there is an assignment of degrees of urgency to wounds or illnesses to decide the order of treatment of a large number of patients or casualties.

This research, through surveying healthcare professionals, will consider common characteristics of patients who rely on emergency departments. It will identify some of the EDs' challenges and provide some recommendations to improving the ED experience.

PROBLEM

Chaos, crowds, and confusion are often descriptions that can be used in an emergency room whether you are a patient or healthcare provider. The burden on these healthcare institutions can be relentless, with EDs often expected to do more with less, handle high-risk populations with additional complications such as financial hardships, and provide quality care in a sometimes-frantic atmosphere.

Systemically, EDs are faced with crowding issues and a wide variety of medical conditions they must treat. As national patient loads escalate, the number of ED facilities decline. "From 1990 to 2009, the number of hospitals with EDs in non-rural areas declined from 2,446 to 1,779, with 1,041 EDs closing and 374 hospitals opening EDs" (Hsia et al., 2011, p. 1978). A 2014 report in the *Journal of the American Medical Association* (JAMA) painted a dissatisfactory picture of the nation's emergency care system, giving it a D+. The report, which examined the CDC's National Hospital Ambulatory Medical Care Survey and interviewed medical professionals, noted that physicians who are overbooked tend to send patients with acute issues "such as urinary tract infections or lacerations in need of suturing" straight to the ED

(Kuehn, 2014). Dr. Jeffrey Schnaider, chair of emergency medicine at the Cook County Health and Hospitals System in Chicago, while downplaying the "D+" rating, said EDs have evolved to accommodate the demand for *sophisticated care* (Kuehn, 2014). Schnaider "noted that sometimes it makes sense to send complex patients to the emergency department where advanced technologies and interdisciplinary care are available, rather than sending them to multiple specialists" (Kuehn, 2014, p. 1001).

While the staffs of EDs are committed to ensuring good health outcomes, these pursuits are often an uphill battle. Staffers often find themselves trying to do more with less as they are besieged with patients. Given the importance of this sector of health care and its broad impact on the health of those less fortunate in many cases, there is a need to continue examining EDs and exploring innovative ways for them to operate more effectively while improving healthcare outcomes.

CHAPTER II

LITERATURE REVIEW

This study surveyed caregiver experiences in Hampton Roads EDs and considered how issues such as crowding, long waits, and bed shortages might influence the care of vulnerable populations such as minorities, low income, health illiterate, mentally ill, and the uninsured (Sonnenfeld et al., 2012; Hong et al., 2007; Kosoko-Lasaki et al., 2009). These population characteristics have intersectionality, thus often such characteristics do not exist categorically exclusive of each other. For example, a population might be an uninsured minority with a language barrier, or people who are both health illiterate and uninsured. Examining emergency departments will shed a light on possible interventions designed to better serve these complex populations as well as explore other avenues of research that too could lead to future solutions that benefit both caregiver and patient at these facilities in Hampton Roads and beyond.

When it comes to long waits in EDs, frustration can turn into less than optimum health outcomes, according to some healthcare providers. "The overall evidence paints a pretty clear picture that under more crowded conditions, quality of care declines," said Dr. Benjamin Sun, an emergency-medicine physician at Oregon Health and Science University (Kincaid, 2017).

Health care in the United States has its share of challenges. The level of care one receives can sometimes depend on who they are. Some populations are limited in terms of healthcare access or choices and inevitably find themselves in the nation's emergency departments (Aday, 2001). These facilities face constant hurdles when it comes to treating those unable to pay for more formal, comprehensive care. Nationwide, EDs buckle under the weight of these populations, faced with managing settings that can be filled at times with confusion and

congestion (Yarmohammadian et al., 2017). But those challenges come with the territory for EDs and the law of the land only encourages the use of these facilities.

In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), which entitles anyone coming into an emergency department to be treated and stabilized regardless of whether they can pay for care or not (CMS, 2012). Also called the anti-dumping law, the EMTALA was "designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer" (CMS, 2012). Despite the goal to improve fairness in healthcare, this mandate is federally unfunded and has had a significant financial impact on the nation's emergency care system (CMS, 2012).

Previous research cites several situations/characteristics worth reviewing when examining the role that EDs play in patient care (Kosoko-Lasaki et al., 2009; Sonnenfeld et al., 2012). The following situations and characteristics pose challenges for EDs.

OVERCROWDING

A very common issue that EDs struggle with is overcrowding, and as annual visits increase, the number of EDs across the nation continues to decline (Hong et al., 2007). A series of *adverse effects* from the crowding issue include: "poorer outcomes for patients, prolonged pain and suffering by some patients, longer waiting times, increased patient dissatisfaction, ambulance diversions, increased transport times, decreased physician productivity, increased frustration from medical staff, and violence in the department" (Hong et al., 2007, p. 152).

The United States Department of Health and Human Services (DHHS) records data on the nation's emergency departments through its National Hospital Ambulatory Care Survey

(NHAMCS). According to the DHHS 2013 survey, 130.4 million people visited EDs, with 37.2 million of the visits being injury-related, 12.2 million visits resulting in hospital admission, and 1.5 million resulting in admission to a critical care unit (NHAMCS, 2013).

Research published by the American Clinical and Climatological Association identifies two key issues in the emergency department crowding phenomenon in the United States. "First, emergency medicine is the only specialty … that has a federal mandate to provide care to any patients requesting treatment. Second, primary care providers are in short supply, forcing sick people to seek medical care in ERs" (Barish et al., 2012, p. 304). Referred to as "the safety net of the safety net," U.S. emergency room "visits account for 11% of outpatient encounters, 28% of acute care visits, and 50% of hospital admissions" (Barish et al., 2012, p. 304).

A 2010 survey by the American Hospital Association estimated that more than 50% of EDs in hospitals were at or over capacity, which given the common use of emergency departments by low-income and poor patients, the declining number of EDs could pose problems. Between 1998 and 2008, the number of hospital-based EDs dropped 3.3 percent, and during the same time period, "ED visits increased by 30% from 94.8 million to 123 million annually" (Hsia et al., 2011, p. 1978). This has left EDs in short supply and made emergency assistance additionally strained, which can affect the quality of care at these facilities. The combination in the decrease of hospital-based EDs and increases in annual ED usage has strained emergency assistance and triggered scenarios where patients leave without being seen (Barish et al., 2012).

Several solutions have been put forward in an effort to stem overcrowding. There have been free-standing emergency rooms, patients with less urgent conditions have been redirected to facilities such as urgent care centers, and ED staffing has been realigned to more adequately

match peak times with resources. Nonetheless, these crowding problems persist. In an atmosphere of overflowing emergency departments, "a decision to open or close a hospital or its emergency department may depend on a wide range of factors, including political considerations, community pressures, local philanthropic support and a hospital's ability to fill its beds with non-emergency department admissions" (Hsia et al., 2011, p. 1984).

Timeliness of care is very important to healthcare quality, particularly in EDs, which deal with urgent needs. A 2012 study on emergency room crowding said that "investigators found that ER patients triaged to the 'sickest' category were waiting more than twice the recommended time limits before being seen by a physician" (Barish et al., 2012, p. 307). Of the 130 million visits to EDs in the U.S. in 2013, more than 19 million waited between an hour and three hours to see a provider. More than 76 million patients spent between two and six hours in an emergency department (NHAMCS, 2013). The average wait time at Sentara Norfolk General Hospital is 36 minutes (Groeger et al., 2014), compared nationally to 30 minutes (CDC, 2015).

STAFFING CONDITIONS

With overcrowding in EDs, having adequate staffing to handle the overflow of patients becomes an issue. Recent research has noted that in situations where you have an excessive number of patients waiting to be seen, being treated, or awaiting release, strategies are necessary to adequately handle patient flow. Those strategies "should focus on the following issues: patient acuity levels, prolonged ED evaluations, inadequate inpatient bed capacity, a severe shortage of staff, problems with access to on-call specialists, and the use of ED by those with no other alternative to medical care, such as the uninsured" (Yarmohammadian et al., 2017, p. 2, 5).

In 2015, a nine-month study surveyed a total of 3,120 patients either treated and discharged from an ED or admitted from an ED and found that "overall, higher levels of registered nurse (RN) staffing in the emergency department were associated with better patient ratings of their care experiences …" (Nelson et al., 2018, p. 394). Recent research also looked at the adverse effects of decreased nursing staffing in EDs. That research examined the medical records at an urban ED for 105,887 patients in 2015 and concluded that "Lower nursing hours contribute to a statistically significant increase in door-to-discharge LOS (length of stay) and the number of LWBS (leaving without being seen) patients, independent of daily ED volume, hospital occupancy and ED admission rate" (Ramsey et al., 2018, p. 496).

ETHNICITY DIFFERENCES

The wait can be longer for some patients, such as African-Americans (James et. al, 2005; Sonnenfeld et al., 2012). According to an analysis of 54,810 visits to 431 emergency departments in the U.S., "non-Hispanic black patients wait longer for ED care than whites primarily because of where they receive that care" (Sonnenfeld et al., 2012, p. 335). "Disparities in waiting times for non-Hispanic Blacks may lead to disparities in the percentage of patients who leave the ED without being seen, introducing barriers in access to a medical screening exam" (Johnston et al., 2011, p. 615).

Additionally, a four-year study (1997-2000) surveyed 20,633 children (below 16) who were treated in an ED and found significant differences in wait times based on ethnicity (James et al., 2005). Non-Hispanic whites were treated almost 10 minutes sooner that non-Hispanic blacks and nearly 16 minutes faster than Hispanic whites. The authors concluded "several

potential explanations for this observation, including discrimination, cultural incompetence, language barriers, and other social factors" (James et al., 2005, p. e310).

National Hospital Ambulatory Medical Care Surveys are performed annually, collecting data on ambulatory care services and their use in hospital emergency and outpatient facilities. Using data from these surveys from 2003 to 2005, researchers concluded that non-Hispanic blacks who were admitted to the hospital via EDs often waited longer for care than other patients (NHAMCS, 2005). "Among patients presenting to the same hospital ED with chest pain during 2003–2005, racial/ethnic minority patients and Medicaid/SCHIP (Children's Health Insurance Program) or uninsured patients were on average about 1.4 times as likely to have waited for more than 60 minutes to see a physician than non-Hispanic Whites and patients with Medicare/private payment sources, respectively" (Johnston et al., 2011, p. 615).

SOCIOECONOMIC STATUS

Socioeconomic status (SES) adds yet another complicated layer to care in emergency departments. SES is one of the key factors contributing to ED use for non-urgent care. One study noted that "Black and Hispanic patients may be more likely to be economically disadvantaged and uninsured, making them less likely to have a primary care provider to turn to when they are ill" (Hong et al., 2007). This study used a standardized survey at an urban ED and recruited 910 patients who presented during peak volume hours of the ED (8 a.m. to midnight) over a five-week span. The study determined SES through gathering data on frequently used indicators such as employment status, insurance status, annual income, and level of education (Hong et al., 2007). The study found not only a relationship between SES and race/ethnicity, but that: "Compared to white patients, black and Hispanic patients were less likely to be insured, less

likely to have graduated from high school, were more likely to be unemployed, and had lower annual incomes" (Hong et al., 2007, p. 154). Of the four SES indicators used in the study, "insurance status and education were associated with a greater likelihood of routine ED use." The study also suggested that minorities use EDs mainly because the lack of insurance, it didn't require a copay, they were economically challenged, and they had no other medical care options (Hong et al., 2007, p. 156).

A six-month study of a county hospital emergency department in California revealed two persistent problems that the ED faced when treating low-income patients: "social use and tenuous financing" (Dohan, 2002). The former -- social use -- arose because of the responsibility of EDs to see all patients who show up at their doors, and the latter posed "a problem because hospital services are often inadequately reimbursed by patients who have Medicaid or are uninsured" (Dohan, 2002, p. 361-362). The research also noted the overcrowding issues at this facility by mostly poor patients and the fact that wealthier patients rarely used the facility and when they did "usually left quickly" (Dohan, 2002).

HEALTH ILLITERACY

Health illiteracy is also an additional challenge in EDs. Many researchers acknowledge the need to improve health communication (Kosoko-Lasaki et al., 2009). Without the ability to obtain and truly understand information on medical services, it is sometimes difficult for patients to make the right decisions when it comes to their health. Patients must be able to easily comprehend information given to them. About 30 million adults in the United States lack basic literacy skills (National Assessment of Adult Literacy [NAAL], 2013). Many of these people day to day face the daunting task of navigating an ever-complicated healthcare system. "There is a

need for plain language interventions targeting low literacy populations that teach chronic disease risk factors and promote screening and disease prevention" (Kosoko-Lasaki, et al., 2009).

There have been many studies (Jordan et al., 2010; Kosoko-Lasaki et al, 2009; Schumacher et al., 2013) on health literacy as the issue relates to emergency services. One study examined health literacy and its relationship to ED usage among adults, noting that in the case of those with limited health literacy, EDs are especially important when it comes to health care and "a risk factor in the overuse of the emergency department" (Schumacher et al., 2013, p. 654). Health literacy was defined by these researchers as "the capacity to obtain, process, and understand health information and services needed to make appropriate health care decisions" (Schumacher et al., 2013, p. 654). The lack of a clear understanding of the purpose of an ED led some patients with limited health literacy to assume that ED care was better care, more accessible, more convenient, and a better environment than alternatives such as an urgent-care facility or primary care physician. Additionally, those with limited health literacy more often stated that they received all their care in EDs, emphasizing their belief that more advance, top-notch care was available in those facilities (Schumacher et al., 2013).

A 2009 study stated that health literacy is a critical element in a patient's ability to "actively participate in their health care" (Jordan et al., 2010, p. 36). This study of 48 patients identified seven necessary abilities: "knowing when to seek health information; knowing where to seek health information; verbal communication skills; assertiveness; literacy skills; capacity to process and retain information; and application skills" (Jordan et al., 2010, p. 40).

MENTAL ILLNESS

Patients with mental illness – or psychiatric patients – often rely on EDs for care. According to a recent study, this population is growing in numbers on its reliance on EDs. "Increasing numbers of psychiatric patients in the ED contribute to the overcrowding of the ED, which increases wait times and demands on ED staff. Many hospitals are faced with keeping patients in psychiatric crisis in the ED for extended periods of time and/or admitting them to the medical service because there is no available mental health services or available psychiatric beds" (Boudreaux et al., 2016, p. 1009). A government report shed additional light on this issue noting that "The rate of mental health/substance abuse-related ED visits increased 44.1 percent from 2006 to 2014, with suicidal ideation growing the most (414.6 percent increase in number of visits)" (Moore et al., 2017, p. 1).

A study into the availability of mental health service "and the admission of 111,527 seriously mentally ill (SMI) patients from the ED in New York State in 2002 noted that SMI because of financial barriers often rely on treatment at hospital EDs," adding that "The three major SMI disorders were schizophrenia, major depression, and bipolar disorders" (Moseley et al., 2008, p. 294). A previous study of mental health-related visits to U.S. emergency departments found that mentally ill patients used ED services four times as much as non-mentally ill patients, and that "from 1992 to 2001, there were 53 million mental health-related visits, representing an increase from 4.9 percent to 6.3 percent of all emergency department visits and an increase from 17.1 to 23.6 visits per 1,000 U.S. population across the decade" (Larkin et al., 2005, p. 671).

INTERSECTIONALITY

Individuals who frequently visit the ED may comprise more than one of the aforementioned characteristics such as low income, health illiterate, and minority. Intersectionality theory situates the integration of such characteristics, which depending on the combination of those characteristics, unique populations are produced in our society (Viruell-Fuentes, 2012). Over the past few years, researchers have evaluated the effects of a combination of traits such as race/ethnicity, gender, class, and income on health and well-being (Sonnenfeld, 2012; Chapman et al., 2013; Dohan, 2002). Using the rubric of intersectionality – which asserts that people often must battle several sources of discrimination and oppression because of race, class, gender, and other markers -- feminist and critical race theorists have developed ways to analyze the meaning and consequences of multiple categories of social group membership (Cole, 2009). For example, if a person is a minority, health illiterate, and uninsured, these three characteristics potentially can provide a triple threat in terms of their access to health care. Researcher Ange-marie Hancock goes further to explain that "while race and gender are commonly analyzed together, to assume that race and gender play equal roles in all political contexts, or to assume that they are mutually independent variables that can be added together to comprehensively analyze a research question, violates the normative claim of intersectionality that intersections of these categories are more than the sum of their parts" (Hancock, 2007, p. 251).

CHAPTER III

DATA AND METHODOLOGY

Using a Qualtrics survey, this research specifically targeted healthcare professionals, most of them registered nurses and all of them with some experience working in emergency departments. This research examined both qualitative and quantitative perspectives on healthcare conditions and patients in emergency departments in Hampton Roads.

Under the advisement of an Old Dominion University School of Nursing faculty member – who also works as a nurse in an emergency department – an 11-question Qualtrics survey was developed. Open-ended questions were chosen to allow for more free responses. Qualtrics provided a simple, web-based survey tool that is intuitive to users. The survey also allowed participants to expound on questions if needed and provide anecdotal information further detailing their experiences in the ED. The survey questions (Table 1) considered the experience of each healthcare professional, the capacity in which each respondent worked in the ED, the types of patients each served, some of the key challenges EDs face, as well as recommendations to improve conditions for both patient and healthcare professional in EDs**.**

Using experiences from the participants, the goal of the research was to provide a snapshot of the experiences of healthcare professionals working in EDs. Participants were recruited using social media and through contacts in the ODU College of Health Sciences with local healthcare professionals in Hampton Roads. Participation in the survey was voluntary and anonymous (IRB approval number 1189046-1: "Emergency Departments and Care for Marginalized Populations").

Table 1. Survey questions

1. How long have you been a healthcare provider?
2. How much experience (number of years/months) have you had working in an emergency department?
3. In what capacity (your position i.e. RN, MD, Tech, Respiratory) did you work in an emergency department? (If in multiple capacities, please list.)
4. What are/were some of the major populations that your worked with in the emergency department? (Use as many descriptors as necessary.)
5. What are/were some of the most common diagnoses and treatment needs for the population in your emergency department?
6. What aspects of emergency departments that you've worked have received positive feedback from patients/clients?
7. What aspects of emergency departments that you've worked have received less positive feedback from patients/clients?
8. What are a couple key challenges that emergency departments face in their quest to provide top-notch service?
9. What types of emergency department clients/patients pose the most challenges in getting registered? Why?
10. What types of emergency department clients/patients pose the most challenges in patient care and discharge planning? Why?
11. If cost were no issue, and you could institute one thing to facilitate improved service in an emergency department, what would it be?

Healthcare professionals were chosen because of their accessibility, expertise, and real-life experiences of working in EDs. The objective was to gather information on several facets of emergency rooms that could open the door to possible interventions to improve communication and other conditions in those spaces as well as fuel suggestions of alternative avenues in research

about healthcare in emergency departments. The experiences of health professionals in Hampton

Roads may be representative of larger discourses in the nation regarding healthcare.

In most cases, the questions were graphed, emphasizing the higher-frequency responses

to the survey questions. Qualtrics also was used to generate word clouds, which convey the

frequency of common words used in response to a question by differentiating each words' size.

Word clouds quickly illustrate common themes found in the survey results (Figures 1-4). This

study provides a big-picture look at the experiences of healthcare professionals in regional EDs

and highlights the issues they deal with and the clients they encounter.

Figure 1. Patient Populations Word Cloud

Figure 2. Patient Symptoms Word Cloud

Figure 3. Patient Positive Remarks Word Cloud

Figure 4. Patient Criticisms Word Cloud

Four of the questions in the Qualtrics survey (Q1-3 and 11; Table 1) required only one response. Seven of the questions (Q4-10; Table 1) allowed participants to provide additional context to the populations served by the ED and highlight key challenges and opportunities for improving ED settings. While the responses is reflective of only those surveyed, the insights provide valuable insight into the experiences of some health professionals in Hampton Roads ED.

Questions 1 and 2 (Table 1) were graphed and dealt with length of time as a healthcare professional and worker in the ED. Graphically (Graph 1-2), the time length was separated into six categories: less than a year, 1-5 years, 6-10 years, 11-20 years, 21-30 years, and more than 30 years. Six other questions were also graphed (Q4-5, 8-11; Table 1), given their tendency to

produce common responses that lent themselves to be represented in a graphical form. In graphing these questions, the number of total responses were counted, and the most common responses totaled together to produce graphable categories, with less common responses assigned to an "other" category (Graphs 3-8).

Two of the questions, which dealt with patient experiences, were not graphed (Q6-7; Table 1); the wide-range of anecdotal responses made categorizing difficult. However, several of those responses were conveyed in bulleted items contained in this study. The responses to these questions were also captured in Word Clouds 3 and 4. Additionally, two other questions in the survey (Q4-5; Table 1) were also captured in Word Clouds 1 and 2.

CHAPTER IV

RESULTS

Twenty-seven healthcare professionals in the Hampton Roads area were surveyed

between March 22 and March 30, 2018. Twenty-four of those survey identified themselves at

registered nurses (RNs). The majority of those surveyed (Graph 2) had six or more years'

experience working in the ED. *In referencing the graphs below, the survey questions are found*

in Table 1.

HEALTHCARE PROVIDER EXPERIENCE

Graphs 1 and 2 provide key information on those surveyed regarding their experience as

healthcare providers and their experience working in emergency departments. In terms of

experience, seven of those surveyed had between one and five years of experience. Thirteen

participants had 11 or more years of experience (Graph 1). Working in ED, 10 of those surveyed

had between one- and 10-years' experience, and 13 had at least 11 years of experience in

emergency departments (Graph 2). Experience, in particularly ED experience, is important for

several reasons. "The nurse in this role provides care for patients in the ED waiting room after

triage. Aims of the role are to assess and monitor the condition of patients in the ED waiting

room, commence interventions early, detect clinical deterioration and improve communication

between patients, families and staff" (Innes et al., 2017, p. 6). Twenty-five of the 27 respondents

self-identified as registered nurses.

Graph 1. Healthcare Provider Experience
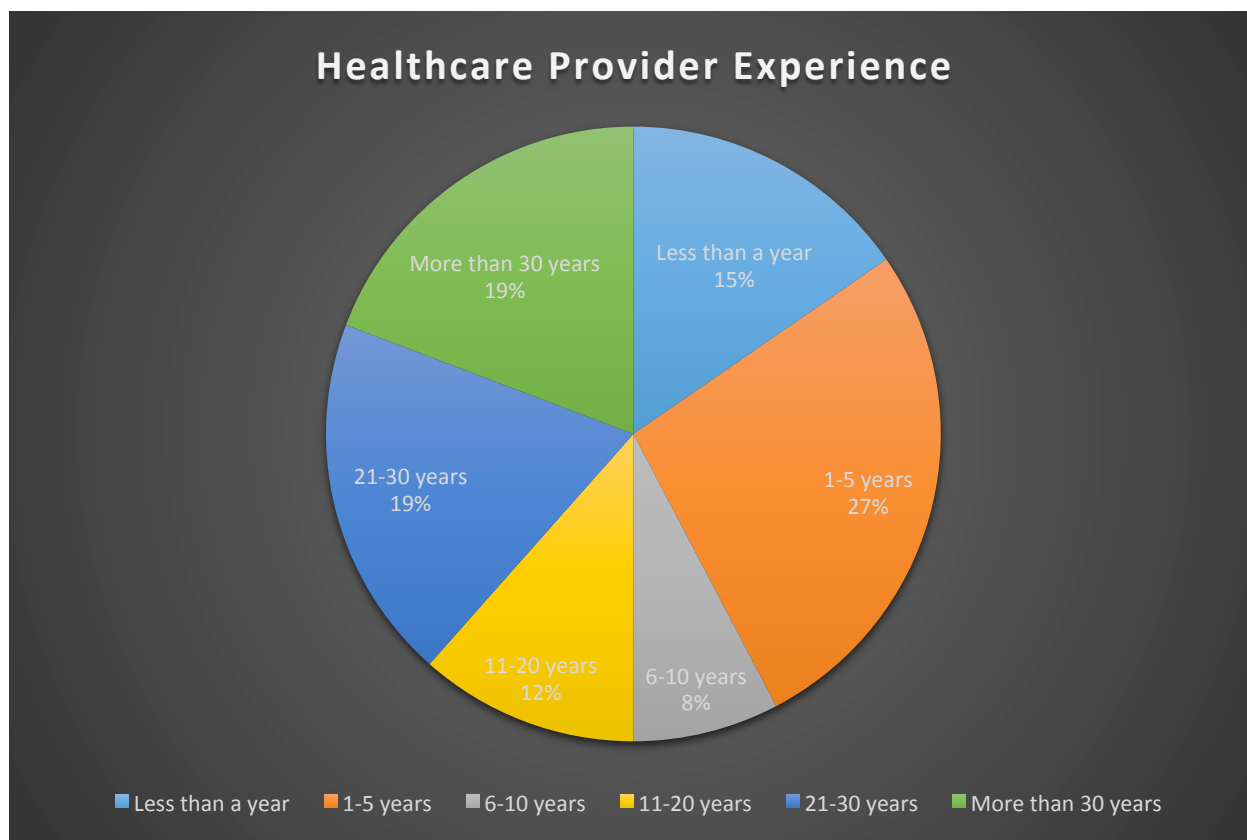
Graph 2. Emergency Department Work Experience
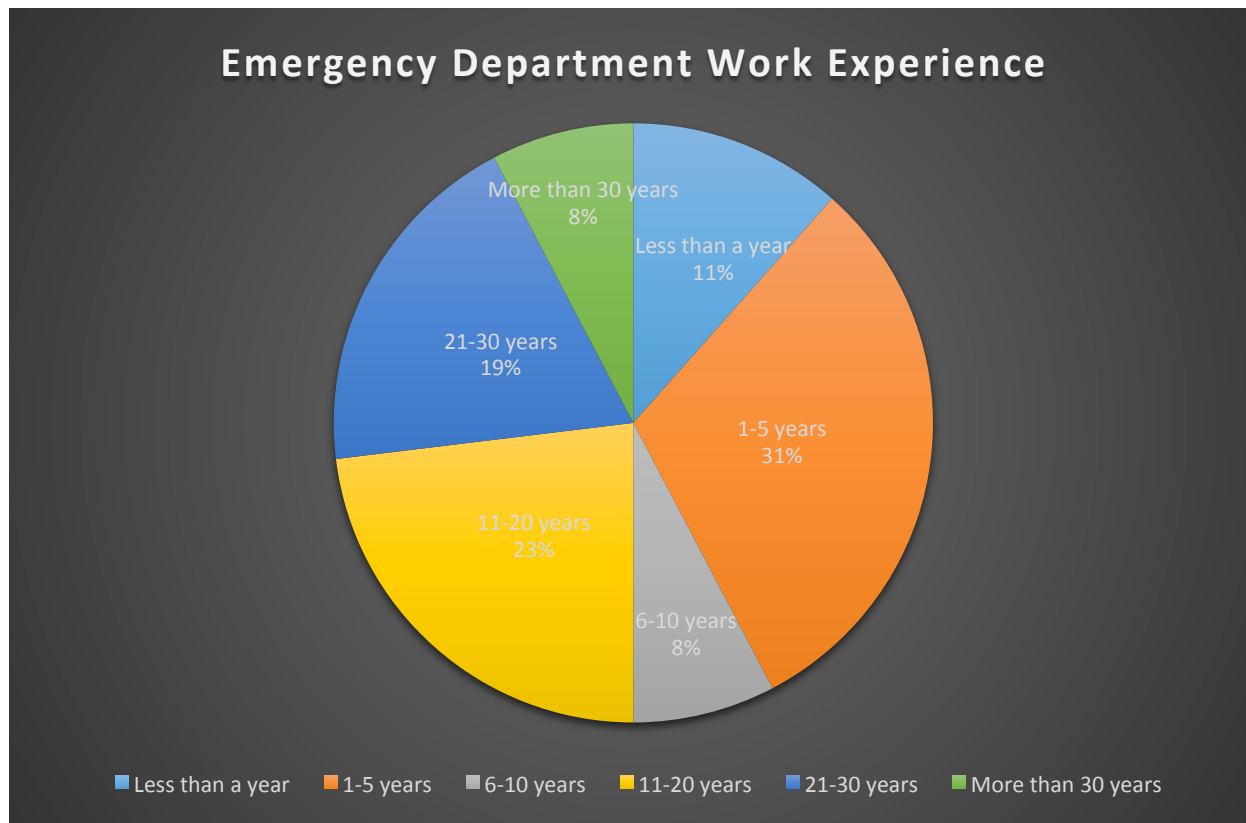
TYPES OF PATIENTS/SYMPTOMS

When asked about the individuals routinely served in emergency departments, survey responses focus on five main categories (Graph 3). While other patients were identified, most were classified as "kids/pediatrics/adolescents" (20%) or "elderly/geriatric" (13%). EDs are tasked with diagnosing and treating a variety of medical issues. In Graph 4, common ED diagnoses included "heart attack" (19 mentions), "breathing problems" (10), "trauma" (8), and "stroke" (7).

Graph 3. Most Common Emergency Department Populations
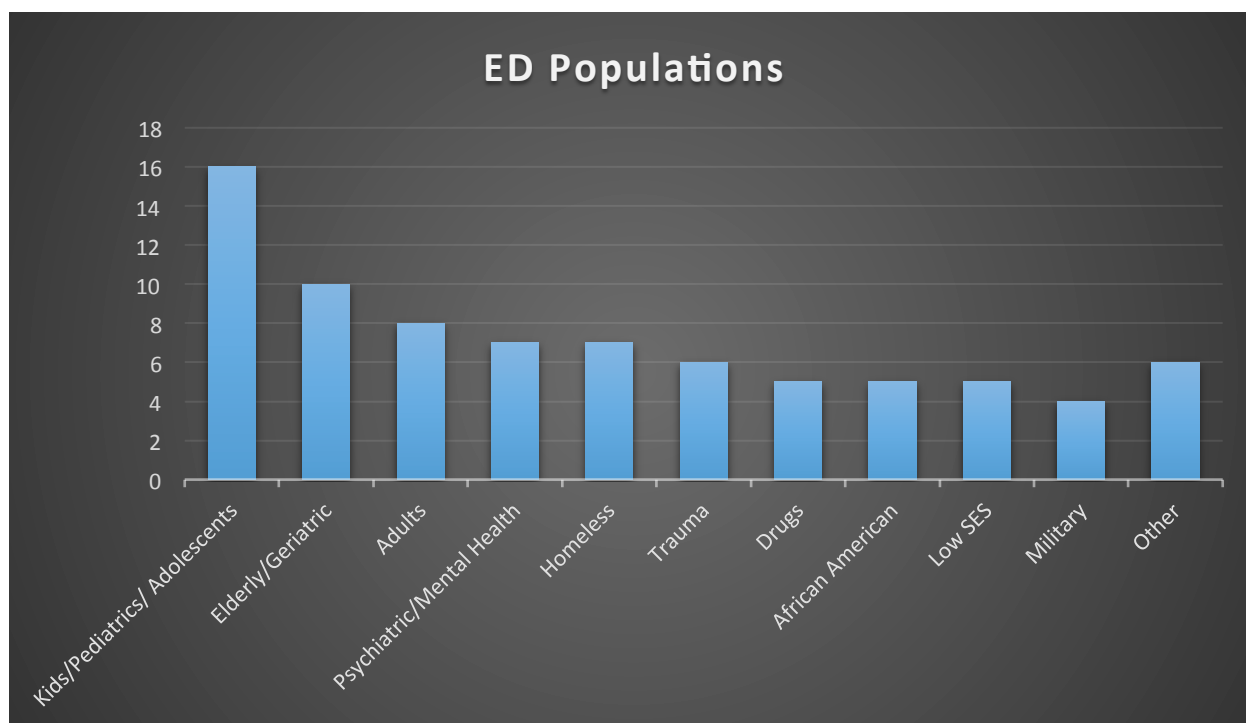
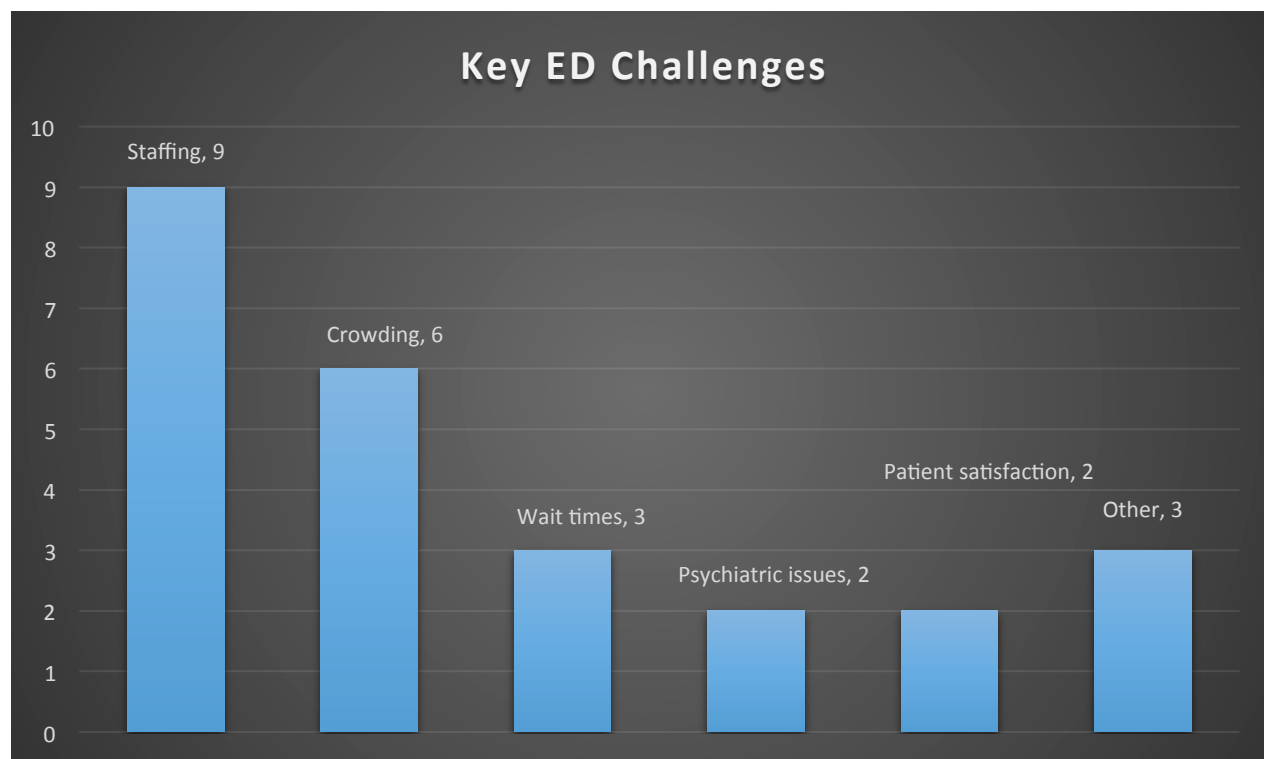Graph 4. Symptoms and Presenting Problems
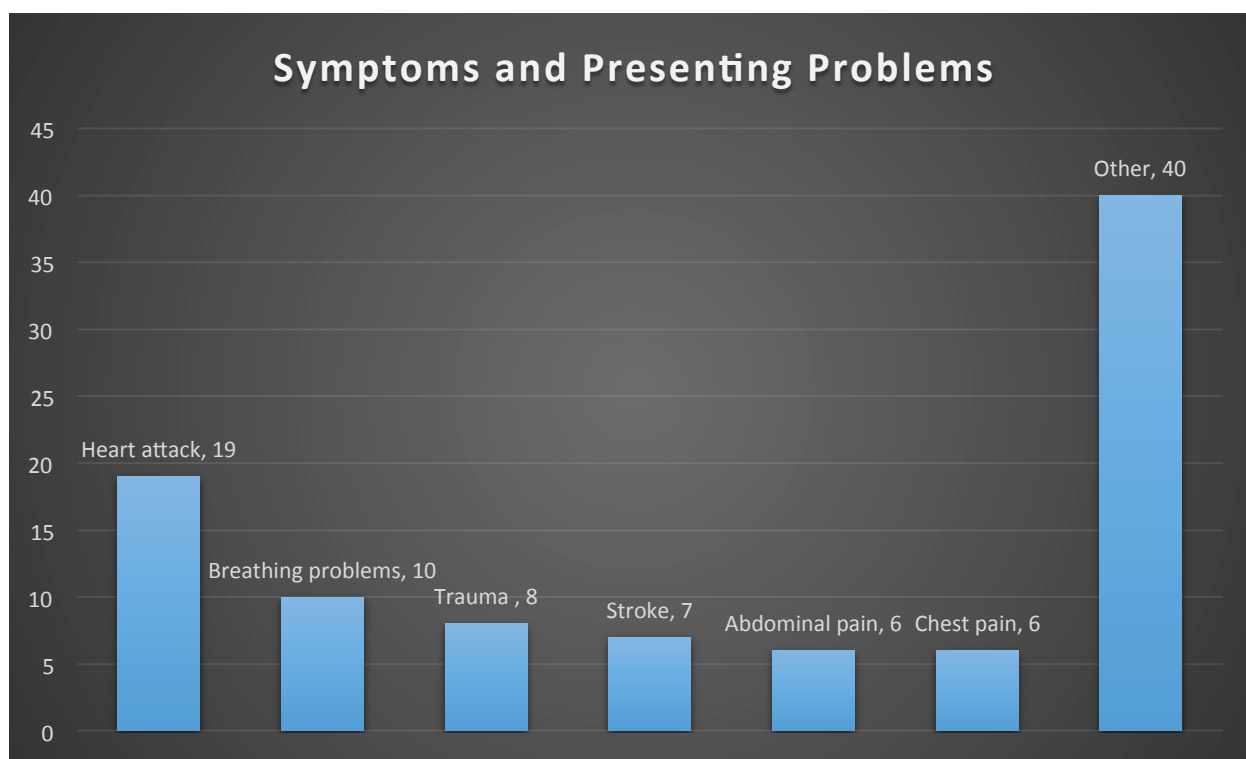
ED CHALLENGES

Graph 5 highlights key emergency department challenges. Survey results showed four

categories with common responses. "Staffing" issues were noted the most along with

"crowding", and "wait times". Some open-ended responses related to Question 8 included:
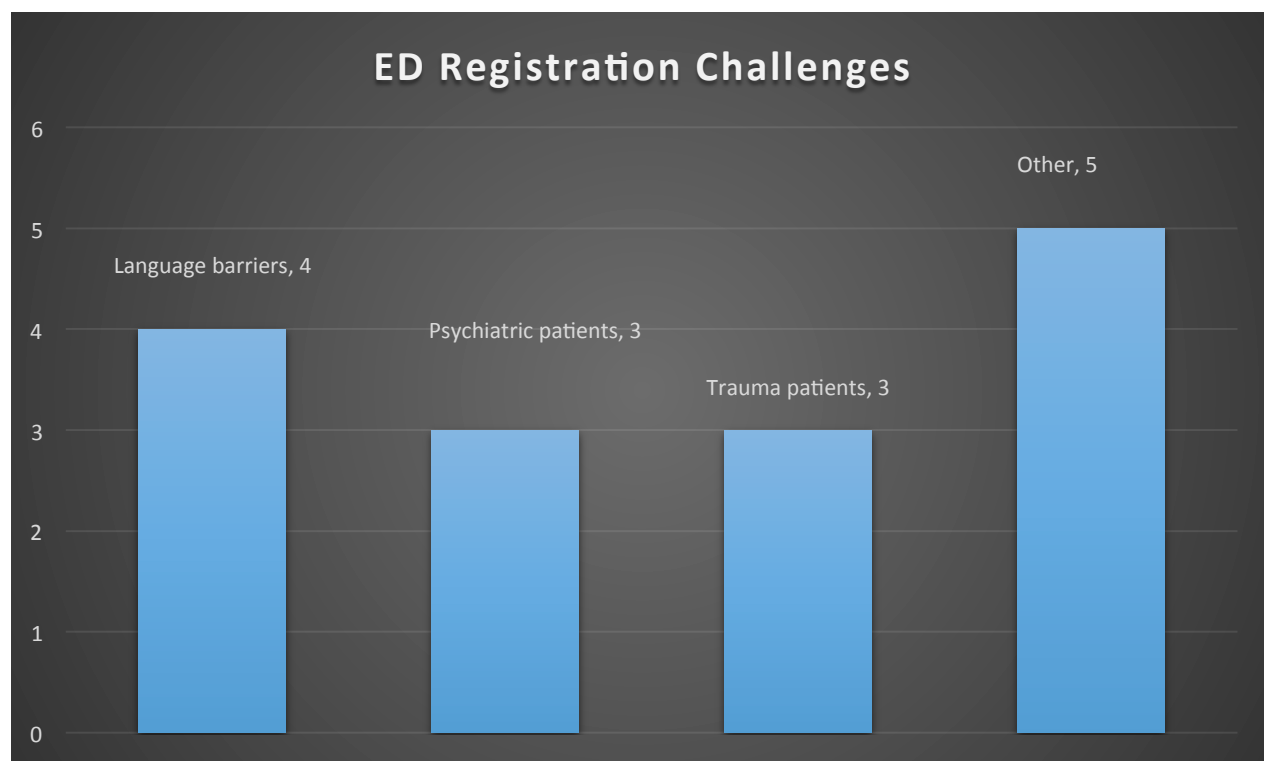
- *Inability to move patients to floors which lengthens stays and causes a backlog of*
  patients

- *Understaffing, wait times for results*

- *Increasing number of people using ED for non-emergent reasons and taking our*
  focus from the ones who truly need our services

- *Overrun with patients seeking general family practice type concerns*

- *Overcrowding and long waits for ER patients because admitted patients are*
  boarded in the ER and backing it up

Graph 6 shows what types of patients pose the most registration challenges at the ED.

Three popular responses surfaced: "language barriers" with four mentions, "psychiatric patients"

(3), and "trauma patients" (3). "Homeless," "no identification," and "uninsured" were also

mentioned by surveyed participants. Graph 7 allowed for open-ended responses to the question

of what types of patients pose the most challenges in terms of ED discharged. Out of 43 total

responses 9 responded "psychiatric," "homeless" (7), "elderly" (6), and "uninsured" (6), and

"financial burdens" (4). Other issues to note were "pain management," "language barriers," and

"non-compliant."
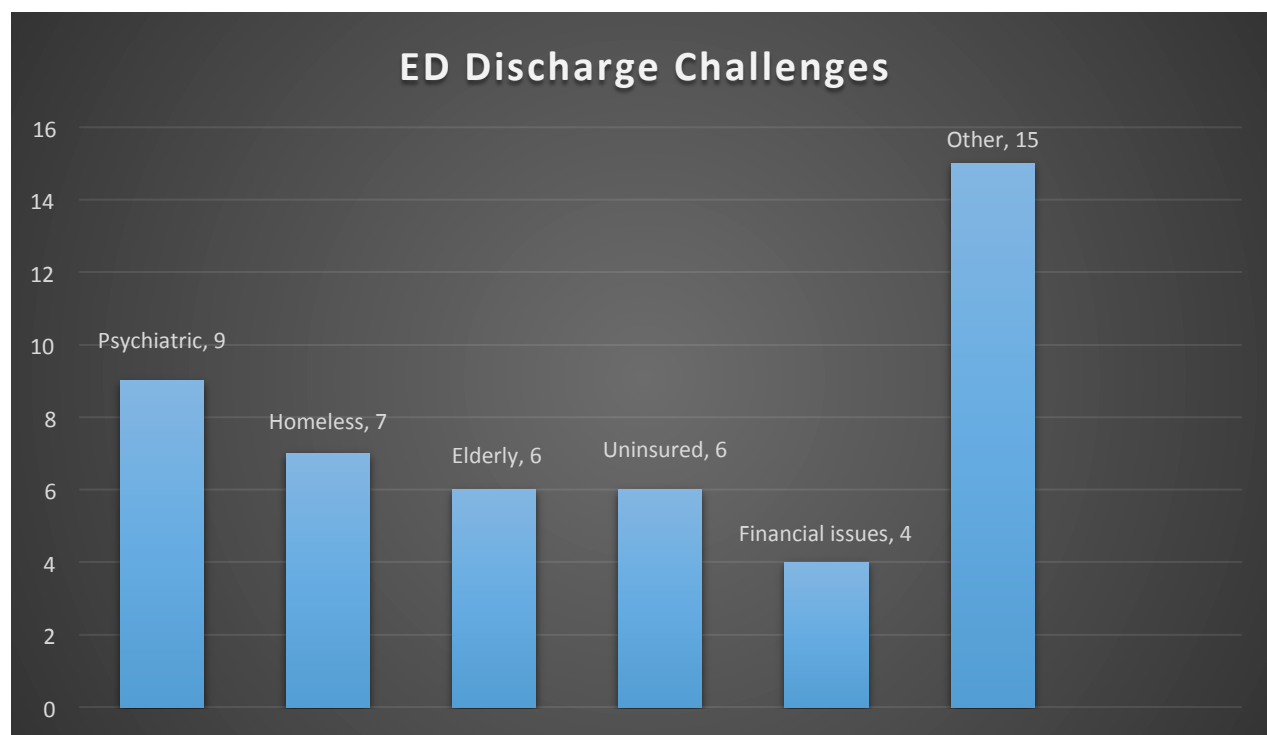
Graph 5. Key Emergency Department Challenges

Key ED Challenges

Staffing, 9

Crowding, 6

Patient satisfaction, 2

Wait times, 3

Other, 3
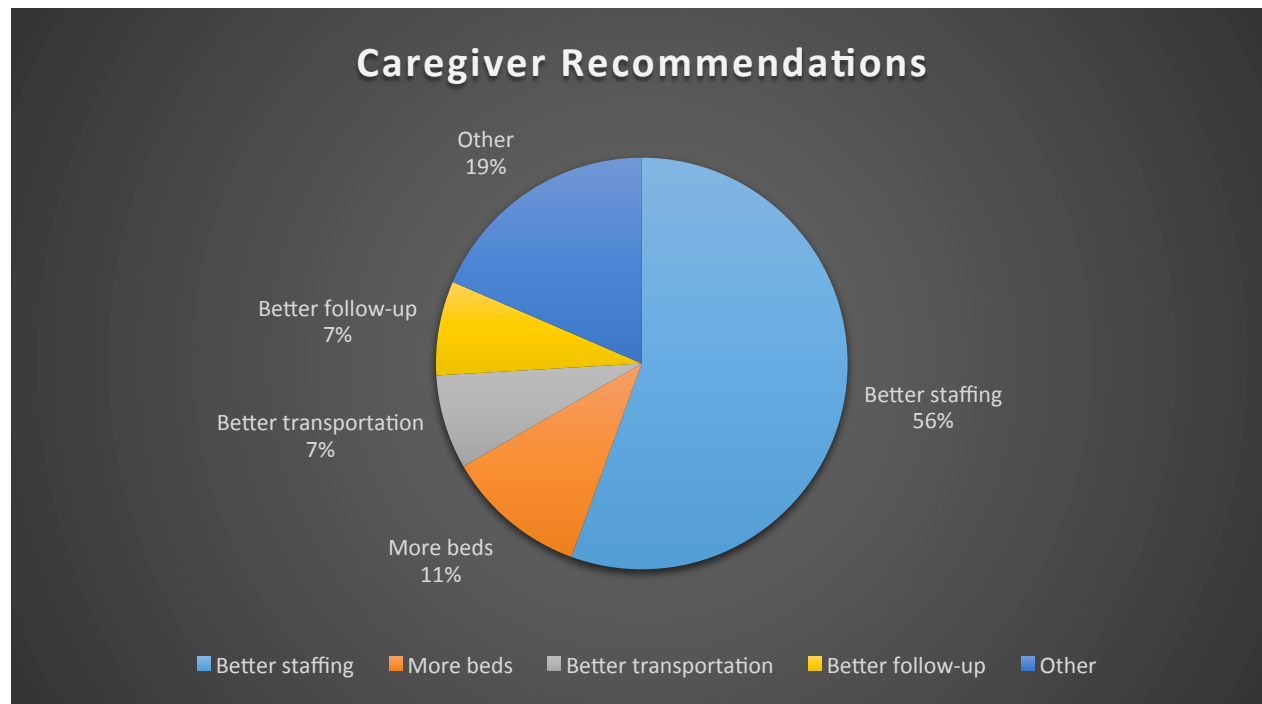
Psychiatric issues, 2

Graph 6. ED Registration Challenges

Graph 7. ED Discharge Challenges

Graph 8. Caregiver Recommendations

POSITIVE/NEGATIVE PATIENT FEEDBACK

Questions 7 and 8, which were not graphed, inquired about feedback healthcare providers received from patients about their treatment in the ED. There was a variety of answers with themes of caring and kindness on one end of the spectrum and long waits on the other end. Some open-ended responses to Question 7, which asked what aspects had received positive feedback from patients, included:

- *Caring nature of the nursing staff*

- *Customer service and fast service*

- *Efficiency, cleanliness*

- *Patient education concerning medical diagnosis and treatment*

- *Daily phone calls from nurses, child specific ED*

Some open-ended responses to Question 8, which asked what aspects had received less positive feedback from patients, included:

- *Waiting time and lack of communication*

- *Appearance of department, small size*

- *Staff overwhelmed*

- *Time it took to be seen, not getting pain medications ordered from the MD*

- *Not having enough time with each patient to have them feel important*

CAREGIVER RECOMMENDATIONS

Graph 8 required a one-answer response and sought recommendations by caregivers to improve ED conditions provided that cost was no issue. "More staffing" was recommended by 15 respondents, the most of any of the other recommendation. Improved transportation, better patient follow-up to check on health status, better direction on alternative avenues of care, more nurse education, and pediatric EDs were also highlighted as possible strategies.

CHAPTER V

DISCUSSION

This survey's results mirror many of the challenging conditions that EDs face as shown

by previous research. Noting the national problem of ED overcrowding, this research shines a

light on the complexities experienced by caregivers in EDs and the overarching need to devise

better ways to ensure positive health outcomes for all who enter their doors. Physicians, nurses,

specialists, and other healthcare professionals lead the charge of ensuring quality service in EDs.

"ED leaders can control some … components. However, many components are controlled by

stakeholders outside the ED whose priority may not be optimizing patient care in the ED"

(Yarmohammadian et al., 2017, p. 7).

Experience in the healthcare profession is very important, and sometimes may be

required for obtaining proper healthcare certifications. Such healthcare experience can provide

an environment for empathy for the patients who healthcare professionals serve. Two studies –

one of 29 family practitioners and 891 diabetes patients and one of 242 doctors and 20,961

diabetes patients – found that "emphatic engagement in patient care leads to improved patient

outcomes. … Empathy is defined as a predominantly cognitive attribute that involves

understanding a patient's concerns, experiences, pain, and suffering combined with a capacity to

communicate this understanding and an intention to help" (Hojat et al., 2013, p. 6-7).

The populations in Hampton Roads emergency rooms are reflective of many who

frequent the nation's EDs. These ED patients span the life cycle, as well as include the homeless,

mentally ill, minorities, and low income – who might find themselves without care were it not

for these facilities (Dohan, 2009; Larkin et al., 2005; Sonnenfeld et al., 2012; Hsia et al., 2011).

Previous studies as well as this one acknowledges evidence of disenfranchised patients relying

on EDs and the safety-net impact of these facilities. It is important for ED caregivers to understand the complexity of these patients in order to provide the best possible care.

But emergency departments face other battles as they struggle to provide care to patients each year in the United States. ED staffs are strained – both in terms of staffing issues and availability of resources (Bernstein et al., 2009; Ramsey et al., 2018; Yarmohammadian et al., 2017). Among the diagnoses and treatment needs are everything from broken bones to heart attacks. Their emergency rooms often overflow with patients and their caregiver-to-client ratios fuel frustrations.

Based on the results of this research, several observations were revealed about healthcare conditions in emergency departments in Hampton Roads area. Registered nurses (RNs) can play an integral role in ensuring that EDs are facilities that properly attend to the needs of the many populations that they serve. When it comes to triage – deciding just "how long the patient can wait to see a physician without their health being in serious jeopardy" – this is often the job of the registered nurse in the ED (Göransson et al., 2008). These healthcare providers also can play a key role in the care and discharge of patients in EDs and thus can provide insight on the needs/struggles of these facilities. In some cases, their perspectives can offer intervention proposals to improve the effectiveness of EDs and result in improved health outcomes.

Surveyed participants note several challenges in the ED. Similar to (James et al., 2005), patients cited long waits, according to survey subjects, as one of the biggest issues in EDs. This observation perhaps opens the door to a missed communication opportunity to ensure that no matter how long the wait, patients and those accompanying them are made to feel comfortable, respected, a priority, and important as they wait for their turn for care.

Since staffing was cited by research subjects as the number one challenge that EDs face, barring additional investment by these facilities to hire more employees, more creative solutions must be considered to mitigate the frustrations on the part of the patient and healthcare provider. Politely redirecting those who use the ED for non-emergencies might be one option (Nelson et al., 2018; Yarmohammadian et al., 2017), but based on the populations that EDs must serve, diverting patients could pose challenges as simple as refusal (Williams et al., 2010).

RESEARCH LIMITATIONS

When considering limitations of this study, the small sample of healthcare professionals surveyed, and the study's regional focus limits the scalability of this study to emergency departments beyond Hampton Roads.

The willingness of those surveyed to answer the questions candidly also could be a limiting factor. A broader, more multi-regional sampling would have provided even more information about Hampton Roads' EDs. Sit-down interviews with healthcare professionals would have opened the door to follow-up questions and could have led to more concrete interventions in ED care.

One major limiting factor of this study is a product of the small sample size. The healthcare provider sample is a convenience sample in that it relies on selecting survey candidates based on the access to and willingness of volunteer participants. While the advantages of this sampling strategy are that it allows for rapid collection of data, the sample size does not adequately represent the full population of ED workers.

While the open-ended nature of Questions 3,4, 6, and 7 yielded a wide-range of responses, a limitation of this type of questioning – as evidenced in the corresponding graphs

(Graph 5, 9, 10) – is that it produced large categories of one-off answers that had to be designated as "other." For instance, among the most common diagnoses/treatments in EDs (Q5; G4), in the "other" category were responses such as miscarriages, depression, dental pain, blood sugar control, headache, kidney stone, and suicidal. In the case of patients posing the most problems in registration in EDs (Q9; G6), the "other" category contained responses such as confused/combative, unresponsive, without IDs, without insurance, and involuntary brought in by police. Some of the responses in both "other" categories could have been worth noting, were the study expanded to a larger sample group beyond Hampton Roads.

More direct follow-up questioning (i.e., multiple choice) might be of benefit for future research on this issue by providing more focused answers based on the initial open-ended questions in the first survey. Providing questions that get at how there is overlap when it comes to conditions and challenges that EDs face could enhance future research and give a voice to some of the voiceless. Also with future research, sit-down interviews could provide a better alternative to a survey by opening a dialogue to better expound on the situations and populations that exist in EDs. Such dialogue could ultimately drive change that positively impacts both caregiver and patient.

CHAPTER VI

CONCLUSION

Based on this research, challenges continue to exist in creating an environment in emergency departments that provides consistent, exemplary care.   Caregivers in Hampton Roads encounter difficulties with staffing and resources in their quest to ensure consistently positive health outcomes for their patients. This research further supports the need for interventions in a healthcare realm that struggles with systemic shortcomings.

There is need for more healthcare attention to be paid to the homeless, who lack health care coverage and, in many cases, have psychological issues, according to this research's findings. Many of these patients do not have identification, so follow-up is virtually impossible in ensuring that they observe any parting medical advice that might prevent their return to the ER. This research reveals a possible shortage in translators in these facilities, which are necessary to mitigate language barriers in a patient's quest for emergency health care. This research also calls attention to the need to provide solutions on vetting those who use EDs for non-emergency needs.

The regional healthcare providers participating in this study provide an exploration of emergency care in Hampton Roads. This research situates common struggles that exist in emergency departments with the intersectionality of patients and does so through the experiences of healthcare professionals who work on the front line of care in these triage facilities.

This research reinforces previous research on health care in emergency departments yet provides insight on an amalgamation of characteristics often present in disenfranchised populations. This research can set the stage for broader, financially funded research opportunities that further reflects both sides of the emergency care issue: the needs of the populations who

depend on such care and the needs of the healthcare providers who serve in emergency departments.

Through the use of a Qualtrics survey, this research allows others to view emergency health care through various prisms, contributing to the understanding of what EDs deal with and the populations they serve. Who are these populations? What are the experience levels of their healthcare professionals? What are common diagnoses and treatment needs? What do patients complain about? What do caregivers complain about? The answers to all of these questions provide a platform that digs deeper into the complexity of emergency care.

POSSIBLE INTERVENTIONS

Research results point to several ED interventions, including increased staffing for emergency departments, more beds, improved communication and follow-up for patients, and more waiting room liaisons to provide direction and answers to patients and those accompanying them. With limited staffs and limited financial resources, in some cases a possible option in ensuring effective outcomes may involve restructuring and reallocation of priorities among those working in the ED. But many of the possible interventions can come with a price tag that is far from modest. Staffing – overwhelmingly cited as the biggest challenge – is an expensive endeavor. With more beds you need more staff and more space, and that means even more money. But reducing the ratio of nurse to patient would likely be an improvement for many EDs.

Currently, some EDs have created "fast track care" to handle such medical issues as allergic reactions, fractures, minor burns, and superficial wounds, and triage liaison physicians (TLPs), who help ED staffs "expedite the care of patients based on their medical needs, especially for those with unpredictable waiting times" (Yarmohammadian et al., 2017, p. 5). In

other cases, EDs have chosen to employ "nonclinical multilingual persons with customer service background" to assist in patient throughput bottlenecks (Sayah et al., 2014, p. 2).

If EDs could provide at least one waiting room liaison (someone to advocate, preliminarily assess and assuage the fears of patients entering the ED), some frustrations experienced in EDs might be addressed, especially when it comes to registration. If a patient suffering from a crisis feels that someone is at their side to help, make their stay more comfortable that could be the difference in ensuring better health outcomes.

Do those who use emergency rooms for non-emergency care know that they should have exercised other options? This is where effective communication can come in. There might be an opportunity to provide clear, simple, multilingual handout information to these patients on what constitutes an emergency and non-emergency and what their possible healthcare options are. While in some cases, these facilities will still have repeat offenders when it comes to patients who overuse EDs, it could lessen the use of EDs by others.

Communication can be a key in EDs, when it comes to setting the stage for persistent patience and caring on the part of healthcare givers. When dealing with overcrowded and potentially chaotic conditions, it is extremely important that patients clearly understand what their personal obligations are to the care they receive after they leave the ED. Keeping these communications simple and providing interpreters at all times will help.

SUGGESTIONS FOR FUTURE RESEARCH

A closer look at the populations would be beneficial. Getting the inside line from the populations who regularly use emergency departments can hold the key to more solutions to the struggles that these facilities face. The homeless and/or those with mental illness will continue to

strain the system. Tracking them and monitoring their healthcare outcomes will be a difficult task, but doing so could offer some important, possibly game-changing solutions.

More research still needs to be done examining the emergency care, and why it continues to be financed and structured the way it is. Those inside – the patients, RNs, doctors, specialists and administrators – as well as policymakers on the outside can be the key to providing those answers. Future research, ultimately, also could be leveraged to incentivize legislation to improve these necessary emergency care facilities and possibly provide additional funding.

More research also should be done that weighs the intersectionality of certain groups that use emergency departments. How is care different for the low-income black woman with no insurance compared to the middle-class Hispanic man with a language barrier? This is but one of many examples worth exploring. However, in order to conduct such research, it will take a willingness of ED patients and certain levels of research approval to ensure that the results are thorough, fair, accurate, and of substantial benefit to both the caregiver and the patient in the long run.

BIBLIOGRAPHY

Aday, L. A. (2001). At Risk in America the Health and Health Care Needs of Vulnerable
Populations in the United States. 2nd ed.. *The Jossey-Bass Health Series*. San Francisco:
Jossey-Bass Publishers.

American Academy of Ambulatory Care Nursing (AACN). (2018). Definition of Professional
Ambulatory Care Nursing. Submitted by the American Academy of Ambulatory Care
Nursing Task Force.

Barish, R. A., Mcgauly, P. L., & Arnold, T. C. (2012). Emergency Room Crowding: A Marker
of Hospital Health. *Transactions of the American Clinical and Climatological
Association* 123: 304–10.

Bernstein, S. L., Aronsky, D., Duseja, R, Epstein, S., Handel, D., Hwang, U., McCarthy, M.,
John McConnell, K., Pines, J. M., Rathlev, N., Schafermeyer, R., Zwemer, F., Schull, M.,
& Asplin, B. R. (2009). The Effect of Emergency Department Crowding on Clinically
Oriented Outcomes. *Academic Emergency Medicine,* 16: 1-10. doi:10.1111/j.1553-
2712.2008.00295.x

Boudreaux, J. G., Crapanzano, K. A., Jones, G. N., Jeider, T. A., Dodge, V. H., Hebert, M. J., &
Kasofsky, J. M. (2016). Using mental health outreach teams in the emergency department
to improve engagement in treatment. *Community Mental Health Journal*, 52(8), 1009-
1014. doi:http://dx.doi.org.proxy.lib.odu.edu/10.1007/s10597-015-9935-8

Centers for Disease Control and Prevention. (2015). Emergency Department Visits.

Centers for Disease Control and Prevention. (2015). Uninsured.

Centers for Medicare & Medicaid Services (CMS). (2012). Retrieved from

> https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/.

Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and Implicit Bias: How Doctors

> May Unwittingly Perpetuate Health Care Disparities. *Journal of General Internal*
> *Medicine* 28, no. 11: 1504-10. http://doi.org/10.1007/s11606-013-2441-1.

Cole, E. R. (2009). Intersectionality and Research in Psychology. *American Psychologist*, 64(3),

> 170-180.

Dohan, D. (2002). Managing Indigent Care: A Case Study of a Safety-Net Emergency

> Department. *Health Services Research* 37, no. 2: 361–76. https://doi.org/10.1111/1475-
> 6773.027.

"EMTALA // ACEP." Accessed March 27, 2017. https://www.acep.org/news-media-top-

> banner/emtala/.

Fields, S., Abraham, A., Gaughan, S., Haines, S., and Hoehn, S. (2016). Language Matters:

> Race, Trust, and Outcomes in the Pediatric Emergency Department. *Pediatric Emergency*
> *Care* 32, no. 4: 222–26. https://doi.org/10.1097/PEC.0000000000000453.

Göransson, K., Ehnfors, M., Fonteyn, M., & Ehrenberg, A. (2008). Thinking strategies used by

> Registered Nurses during emergency department triage. *Journal of Advanced Nursing,*
> *61*(2), 163-172.

Groeger, L., Tigas, M. & Wei, S. (2014). ER Wait Watcher. *ProPublica*. Accessed April 11,

> 2017. https://projects.propublica.org/emergency/.

Hancock, A. (2007). Intersectionality as a Normative and Empirical Paradigm. *Politics Gender*

> 3, no. 2: 248–254. https://doi.org/10.1017/S1743923X07000062.

Hojat, M., Louis, D. Z., Maio, V., & Gonnella, J. S. (2013). Editorial: Empathy and Health Care
Quality. American Journal of Medical Quality, 28(1), 6-7.
http://dio.org/10.1177/1062860612464731

Hong, R, Baumann, B. M., & Boudreaux, E. D. (2007) The Emergency Department for Routine
Healthcare: Race/ethnicity, Socioeconomic Status, and Perceptual Factors. *Journal of
Emergency Medicine* 32, no. 2: 149–58. https://doi.org/10.1016/j.jemermed.2006.05.042.

Hsia, R. Y.; Kellerman, A. L.; and Shen, Y. (2011). Factors Associated with closures of
Emergency Departments in the United States. *JAMA : The Journal of the American
Medical Association* 305, no. 19: 1978–85. https://doi.org/10.1001/jama.2011.620.

Hsia, R. Y., Asch, S. M., Weiss, R. E., Zingmond, D., Liang, L., Han, W., McCreath, H., & Sun,
B. C. (2011). Hospital Determinants of Emergency Department Left Without Being Seen
Rates. *Annals of Emergency Medicine* 58, no. 1: 24–32.e3.
https://doi.org/10.1016/j.annemergmed.2011.01.009.

Innes, K, Jackson, D., Plummer, V., & Elliott, D. (2017). Emergency Department Waiting Room
Nurse Role: A Key Informant Perspective. *Australasian Emergency Nursing Journal* 20,
no. 1: 6–11. https://doi.org/10.1016/j.aenj.2016.12.002.

James, C A., Bourgeois, F. T., & Shannon, M. W. (2005). Association of Race/ethnicity with
Emergency Department Wait Times. *Pediatrics* 115, no. 3: e310–15.
https://doi.org/10.1542/peds.2004-1541.

Johnston, V. & Bao, Y. (2011). Race/Ethnicity-Related and Payer-Related Disparities in the
Timeliness of Emergency Care in U.S. Emergency Departments. *Journal of Health Care
for the Poor and Underserved* 22(2):606–620. Johns Hopkins University Press.

Jordan, J. E., Buchbinder, R., & Osborne, R H. (2010). Conceptualizing Health Literacy from the

    Patient Perspective. *Patient Education and Counseling* 79, no. 1: 36–42.

    https://doi.org/10.1016/j.pec.2009.10.001.

Kincaid, E. (2017). How to Fix the Emergency Room. *Wall Street Journal*, September 13, sec.

    Life. https://www.wsj.com/articles/how-to-fix-the-emergency-room-1505268780.

Kosoko-Lasaki, S., Cook, C. T., & O'Brien, R. L. (2009) Cultural Proficiency in Addressing

    Health Disparities. Sudbury, Mass.: Jones and Bartlett Publishers.

Krumpal, I. (2013). Determinants of Social Desirability Bias in Sensitive Surveys: A Literature

    Review. *Quality and Quantity; Dordrecht* 47, no. 4: 2025–47.

    http://dx.doi.org.proxy.lib.odu.edu/10.1007/s11135-011-9640-9.

Kuehn, B. M. (2014). Report Card Gives US Emergency Care System a D+. *JAMA* 311, no. 10:

    1001–2. https://doi.org/10.1001/jama.2014.1146.

Larkin, G. L., Claassen, C. A., Emond, J. A., Pelletier, A. J., & Camargo, C.A. (2005). Trends in

    U.S. emergency department visits for mental health conditions, 1992 to 2001. Psychiatric

    Services (Washington, D.C.), 56(6), 671-677. Retrieved from

    http://proxy.lib.odu.edu/login? url=https://search-proquest-

    com.proxy.lib.odu.edu/docreview/67905222?accountid=12967

Moore, J., Stocks, C., & Owens, P. L. (2017). Trends in Emergency Department Visits, 2006–

    2014. Agency for Healthcare Research and Quality. Statistical Brief #227.

Moseley, C., Shen, J., & Cochran, C. (2008). Mental Health Services Availability and Admission

    of the Seriously Mentally Ill From the Emergency Department. *Journal of Health and*

    Human Services Administration, 31(3), 292-308. Retrieved from

http://proxy.lib.odu.edu/login?url =https://search-proquest-

com.proxy.lib.odu.edu/docview/200014746?accountid=12967

"National Assessment of Adult Literacy (NAAL)." Accessed December 8, 2018.

https://nces.ed.gov/naal/kf_demographics.asp#3.

"National Hospital Ambulatory Medical Care Survey: 2013 Emergency Department Summary

Tables," 2013, 38.

Nelson, D., Hearld, L. R., & Wein, D. (2018). The Impact of Emergency Department RN

Staffing on ED Patient Experience. *Journal of Emergency Nursing*, 44(4) 394-401.

Ramsey, Z., Palter, J. S., Hardwick, J., Moskoff, J. Christian, E. L. & Bailitz, J. (2018).

Decreased Nursing Staffing Adversely Affects Emergency Department Throughput

Metrics. *Western Journal of Emergency Medicine* 19, no. 3 (May 2018): 496–500.

https://doi.org/10.5811/westjem.2018.1.36327.

Rosenthal, & Lobel. (2011). Explaining racial disparities in adverse birth outcomes: Unique

sources of stress for Black American women. Social Science & Medicine, 72(6), 977-

983.

Sayah, A., Rogers, L., Devarajan, K., Kingsley-Rocker, L., & Lobon. L.F. (2014). Minimizing

ED Waiting Times and Improving Patient Flow and Experience of Care. *Emergency

Medicine International*. https://doi.org/10.1155/2014/981472.

Schumacher, R., Hall, G., Davis, C., Arnold, L., Bennett, D., Wolf, S., & Carden, L. (2013).

Potentially Preventable Use of Emergency Services: The Role of Low Health Literacy.

Medical Care 51, no. 8: 654–58. https://doi.org/10.1097/MLR.0b013e3182992c5a.

Sonnenfeld, N., Pitts, S. R., Schappert, S. M., & Decker, S. L. (2012). Emergency Department Volume and Racial and Ethnic Differences in Waiting Times in the United States. *Medical Care* 50, no. 4: 335–41. https://doi.org/10.1097/MLR.0b013e318245a53c.

U.S. Department of Health and Human Services, Affairs, Assistant Secretary for Public. (2013). Preventive Care. Retrieved from https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html.

Viruell-Fuentes, E. A., Miranda, P. Y. and Abdulrahim, S. (2012). More than Culture: Structural Racism, Intersectionality Theory, and Immigrant Health. *Social Science & Medicine*, Part Special Issue: Place, migration & health, 75, no. 12: 2099–2106. https://doi.org/10.1016/j.socscimed.2011.12.037.

Williams, K., Mehta, B., Peterson, C., & Sheerin, C. (2010) Diverting Patients from a Paediatric Emergency Department to Primary Care - Does It Work? *Pediatric Research* 68: 372–73. https://doi.org/10.1203/00006450-201011001-00734.

Yarmohammadian, M. H., Rezaei, F., Haghshenas, A. & Tavakoli, N. (2017). Overcrowding in Emergency Departments: A Review of Strategies to Decrease Future Challenges. *Journal of Research in Medical Sciences : The Official Journal of Isfahan University of Medical Sciences* 22. https://doi.org/10.4103/1735-1995.200277.

APPENDIX

RESEARCH APPROVAL

OLD DOMINION UNIVERSITY

OFFICE OF THE VICE PRESIDENT FOR RESEARCH

Physical Address
4111 Monarch Way, Suite 203
Norfolk, Virginia 23508
Mailing Address
Office of Research
1 Old Dominion University
Norfolk, Virginia 23529
Phone(757) 683-3460
Fax(757) 683-5902

DATE: March 26, 2018

TO: Irvin Harrell, Masters of Arts in Humanities
FROM: Old Dominion University Arts & Letters Human Subjects Review Committee

PROJECT TITLE: [1189046-1] Emergency Departments and Care for Marginalized Populations
REFERENCE #:
SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS
DECISION DATE:

REVIEW CATEGORY: Exemption category # 6.2

Thank you for your submission of New Project materials for this project. The Old Dominion University Arts & Letters Human Subjects Review Committee has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

We will retain a copy of this correspondence within our records.

If you have any questions, please contact Randy Gainey at 757-683-4794 or rgainey@odu.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Old Dominion University Arts & Letters Human Subjects Review Committee's records.

Generated on IRBNet

VITA

Irvin B. Harrell
Graduate Program in Humanities
Old Dominion University
Norfolk, VA 23529

EDUCATION

B.S. in Journalism (1989), University of Florida, Gainesville, Florida

PROFESSIONAL EXPERIENCE

Coordinator for Strategy & Marketing, College of Health Sciences, ODU Oct. 2014-present

Freelance communications consultant, technical writer   April 2014-present

Associate Editor, Inside Business Quarterly   June 2008-Dec. 2018

Urban Editor, The Virginian-Pilot   May 2013-April 2014

Suburban Editor, The Virginian-Pilot   Dec. 2012-April 2013

Assistant Business Editor, St. Louis Post-Dispatch   Sept. 2007-Dec. 2012

Director of Recruitment/Community Outreach, Post-Dispatch   Oct. 2007- Dec. 2012

Political Editor, Post-Dispatch   Aug. 2005-Oct. 2007

Night City Editor, Assistant City Editor, Post-Dispatch   March 2005-Aug. 2005

Assistant City Editor, The Detroit News   July 2004-Feb. 2005

Night City Editor/Asst. News Editor S. Fla. Sun-Sentinel   June 1999-Jan.2003

Copyeditor, designer St. Petersburg Times   Nov. 1998-June 1999