9-19-2024

Improving Emergency Department Utilization Rates and Quality of Health Among Uninsured Hispanics

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Walden University
2024

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by

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Integrative Review Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Healthcare Administration

Walden University

November 2024

Abstract

Solutions are needed to address the overutilization of emergency departments (EDs) for ongoing and non-emergency conditions among uninsured Hispanic patients. The purpose of this review was to synthesize available evidence related to hospital utilization rates for non-emergency conditions and quality of health and to provide strategies for leaders to reduce ED utilization rates for uninsured Hispanics. An integrative review was conducted of existing literature published between 2020 and 2024. Thematic analysis identified four significant themes: (a) insurance coverage, (b) high-risk uninsured patients, (c) ED, and (d) healthcare payment models. The 12 subthemes identified were (a) non-expansion Medicaid states, (b) delay in healthcare services, (c) financial barriers, (d) chronic conditions, (e) medication costs and adherence, (f) Emergency Medical Treatment and Labor Act, (g) frequent and treat-and-release visits, (h) healthcare costs, (i) primary care services and accessibility, (j) healthcare quality, (k) fee-for-service model, and (l) value-based reimbursement strategies. The Donabedian SPO model supports healthcare administrators and community leaders in implementing strategies to improve ED utilization rates. These strategies include insurance expansion, funding for unexpected healthcare emergencies, collaborative work with community-based healthcare providers, transition to outpatient and primary care services, value-based care, and post discharge programs. Such strategies can permit EDs to provide coordinated medical care to high-risk uninsured Hispanic patients, allowing for positive social change through a reduction in ED utilization rates for non- emergency medical conditions and enhancement in patients' quality of health.

Part 1: Practice-Based Problem

Problem of Interest

In the United States, Hispanics are the largest ethnic minority group, and in 2018, they represented 18.6% of the total population (Zambrana et al., 2021). According to Lin et al. (2021), Hispanics have the highest uninsured rates across the country, and factors such as employment status, income, education, and marital status are important determinants for healthcare access disparities and influence quality of health. For instance, uninsured individuals living in non-expansion Medicaid states have continued to use healthcare services in the emergency department (ED) and have increased hospital admission rates: 1 in 10 visits and 1 in 20 hospital discharges were made by uninsured people (Singer et al., 2019). Uninsured Hispanics are more likely to visit the ED for an ongoing health condition, have confirmed not having a usual source of medical care, and access non-emergency services for less timely care, resulting in receiving medical care from poor-quality facilities (Parast et al., 2021).

ED use by uninsured individuals is a result of the Emergency Medical Treatment and Labor Act (EMTALA), which mandates that hospitals provide emergency care for all incoming patients including a medical screening and stabilization of the medical condition, regardless of the patient's insurance status (Kraus et al., 2020). As a result, continuous ED use can be attributed to 24/7 availability, lack of insurance coverage, and affordability of services (Cronin et al., 2020). The EMTALA mandate and 24/7 availability opens the door for primary care services to be accessed in the ED, which ultimately increases the healthcare utilization rate (Kraus et al., 2020). Consequently,

there's a need to further examine the rates of ED use by uninsured Hispanics and for non-emergency conditions with its potential impact on quality of health.

Healthcare Administration Problem

Background

By year 2065, the Hispanic population is expected to constitute 24% of the U.S. population (Zambrana et al., 2021) and have the youngest demographic group with 31% of Hispanic Americans under the age of 19 (U.S. Department of Health and Human Services, 2021). Hispanic subgroups are Mexicans with 61.4%, Puerto Ricans with 9.6%, Central Americans with 9.8%, South Americans with 6.1%, and Cubans with 3.9% (U.S. Department of Health and Human Services, 2021). As a result of demographic changes, gender, age, immigration status, and language are contributing factors of ED use for non-emergency conditions. ED trends reveal that young women, ages 18 to 34, compared to men, had the highest rate of uninsured ED visits and resided in large metropolitan cities with low-income levels (Ukert & Giannouchos, 2023). In other studies, women were more frequent ED users (Cronin et al., 2020) and were 41% more likely to access healthcare services at the ED for non-emergency visits (Bornais et al., 2020), including non-emergency preventable and primary care which can be treatable at outpatient facilities (Ukert & Giannouchos, 2023).

Al Rifai et al. (2021) stated how younger adults, ages 18–34, who live below the poverty line are without healthcare insurance, mostly Hispanic, have less than a high school education, and low economical levels. This population has reported healthcare barriers when accessing healthcare services including transportation, health insurance, unemployment, and living in a non-expansion Medicaid state (Al Rifai et al., 2021).

Uninsured working adults, ages 18–64, visit the ED for ongoing medical care for chronic conditions and report higher periods of undergoing care without insurance coverage (Choi et al., 2020). Millennials, ages 23–38, within the Hispanic population represent the new demographic shift when it comes to age due to socioeconomic challenges, including income, housing, education, and occupation; such changes have resulted in younger Hispanic adults experiencing healthcare barriers and health disparities (Zambrana et al., 2021).

Immigration status plays an important role in healthcare access and needs of undocumented immigrants as well as foreign-born individuals within the Hispanic population. Ayón et al. (2020) described how, in the United States, approximately 70% of undocumented immigrants are of Hispanic origin and around 60% do not have health insurance, which is 15% of the entire population without coverage. As time progresses, they are unprepared for healthcare needs such as waiting for chronic conditions to worsen due to receiving less medical care (Ayón et al., 2020). Health characteristics include chronic conditions such as liver disease, high blood pressure, and high rates of obesity (Ayón et al., 2020). Reasons for not seeking timely medical care include having to disclose home address when completing registration paperwork due to deportation concerns when accessing healthcare services, and language barriers influence the ability to comprehend medical information (Ayón et al., 2020); almost one-third report limited English proficiency (Escobedo et al., 2023).

Language is key when understanding why adults with limited English proficiency experience unproductive patient–physician communication, absence of health insurance coverage, and inadequate medical care such as primary care services (Ramirez et al.,

2022). Spanish-speaking patients experience disparities when accessing healthcare services resulting in health disadvantages among the Hispanic population (Oh et al., 2020). Examples of language-related difficulties include diabetic patients experiencing a lack of control over glycemic levels, low probabilities of accessing colorectal cancer screening, delays in medical care such as dental visits, flu shots, and pneumonia vaccines (Oh et al., 2020). Escobedo et al. (2023) described how language differences between healthcare professionals and Hispanic patients with limited English proficiency increase the chances of language confusion, perceptions of poor medical care, frustration, emotional stress; patients are less likely to mention medical symptoms resulting in medical distrust when accessing healthcare services without professional Spanish interpretation.

Having adequate healthcare insurance has a direct impact when people need to access healthcare services. Uninsured people are far more likely than those with insurance to postpone health care; therefore, the consequences can be severe, especially when preventable and chronic conditions go undetected (Garfield et al., 2019). For the uninsured, 32.1% of the 45–64 age group, health consequences include chronic health conditions such as asthma, diabetes, cancer, and hypertension as well as experiencing healthcare access barriers (Choi et al., 2020). Patients with chronic liver diseases were younger, more frequently women, reported unplanned ED visits, and experienced complications when affording medical bills (Lago-Hernandez et al., 2021) including prescription drug costs resulting in medication nonadherence (Han et al., 2020).

Across the United States, Hispanics have the highest uninsured rates (Lin et al., 2021), and 45% of uninsured individuals do not qualify for the Affordable Care Act

because of residing in a non-expansion Medicaid state as well as income, immigration, and work status (Garfield et al., 2019). In 2017, there was an increase in unsubsidized premiums for insurers due to an end to cost-sharing reductions, later in 2018, for ages 18–64; 13.3% did not have insurance coverage, and insurance rates were higher for Hispanics and those who are poor or near-poor (Choi et al., 2020). Such change within the healthcare system allowed for states to opt out of Medicaid and to evade additional expenses resulting in the Medicaid coverage gap (Levitt, 2021). Individuals within the Medicaid gap have incomes higher than the state's eligibility for Medicaid, but below the poverty lines, which makes these individuals ineligible for any subsidies under the Affordable Care Act, leading to uninsured status (Drake et al., 2024). Uninsured Hispanics within the Medicaid coverage gap account for between 21% and 26% of the estimated 1.5 million individuals in this insurance gap (Drake et al., 2024) and were twice as likely to report fair or poor health (Zhang & Wu, 2021). Uninsured people, between the ages of 18 to 64, continue to use the ED for healthcare access due to less access to government-sponsored insurance (Singer et al., 2019).

Choi et al. (2020) stated that in states without Medicaid expansion, from 2014 to 2017, 15,600 adults ages 55 to 64 died prematurely compared to 19,200 adults within Medicaid expansion states whose lives were saved. These authors explained how the uninsured obtain medical care from the ED more often than those individuals with private insurance and use it less than Medicaid recipients (Choi et al., 2020). The 60% of uninsured adults who reported having contact with a healthcare professional used safety-net health systems, for instance, a public hospital, which does not reduce the access gap leading for the financial hardship to fall on the uninsured (Choi et al., 2020) due to

frequent treat-and-release visits in the ED as an effect of lack of access to other healthcare alternatives (Scott et al., 2021). Uninsured adults have contributed to the increase in hospital admission rates (Singer et al., 2019) increased medical complications, longer hospital stays, higher medical charges, and self-pay (Choi et al., 2020).

The U.S. healthcare system is a fee-for-service model indicating how healthcare providers receive reimbursement for the delivery of services, but this does not guarantee nor consider any outcome metrics resulting in the lack of accountability and equity during the delivery process (de Silva Etges et al., 2023). Therefore, value-based reimbursement strategies are implemented for healthcare facilities, including EDs, to focus on quality of care rather than the volume of patients who access healthcare services. Such an initiative provides financial incentives to healthcare providers who deliver high-quality services, leading to better patient outcomes without an increase to costs (de Silva Etges et al., 2023).

There are two goals under the value-based care program. The first goal is to provide continuous medical care from the moment a patient receives a diagnosis in the ED, including procedures, medications, exams, and post-acute care, to the moment of hospital discharge (de Silva Etges et al., 2023). The second goal, after hospital discharge, is to avoid repeated ED visits by providing transitional care to other medical facilities for uninsured patients and socially disadvantaged populations who are high-frequency ED users (Biese et al., 2022). For vulnerable adults, not having health insurance results in a lack of preventive care (Choi et al., 2020), and for patients who access healthcare services from an ED, that does not support value-based care models (Biese et al., 2022) and leads to compromised health (Choi et al., 2020).

Operational Problem

Without uninsured Hispanics having a usual source of care comes the overutilization of the ED and for ongoing and non-emergency medical conditions. Alnasser et al. (2023) stated reasons for non-emergency visits are (a) routine examinations and/or primary care services; (b) medication refills; (c) laboratory tests; (d) to obtain a sick leave form; (e) headaches and migraines; (f) ear, nose, and throat infections; (g) wound care; (h) fatigue; and (i) upper respiratory symptoms. Among patients who visited the ED, 61.4% are for non-emergency conditions, and such visits result in a single diagnosis and not hospitalization (Alnasser et al., 2023).

Ideal State of Operations

The Centers for Disease Control and Prevention (CDC) previously stated the national average for hospital utilization rates in the ED utilization is 33 per 100 visits for uninsured patients (Cairns et al., 2023). The Agency for Healthcare Research and Quality (2017) provides public data on what defines high-frequency ED utilization rate as four or more visits in the previous 12 months or three or more prior visits in the previous 3 months or one or more prior visit in the previous 72 hours, indicating the acceptable standard is three or less ED visits yearly. Uninsured Hispanics use the ED for non-emergency services accounting for three or more visits, per each patient, within the last 6 months (Parast et al., 2021). According to existing literature, it is safe to assume how uninsured Hispanics who do not have a usual source of medical care will continue to access non-emergency services and for ongoing medical conditions (Parast et al., 2021). This results in disproportionately higher rates of uninsured ED visits for Hispanics ages 18 to 34 (Ukert & Giannouchos, 2023). Establishing a utilization rate objective and

having a usual source of medical care post-ED visit can potentially result in hospital utilization rates to be at the national level of 33 per 100 yearly visits for uninsured patients (Cairns et al., 2023).

Professional Practice Gap Statement

Evidence show that uninsured Hispanics use the ED for non-emergency healthcare services accounting for three or more visits, per patient, within the last 6 months (Parast et al., 2021). This study was conducted to research methods to bring the ED utilization rate down to the CDC national average of 33 per 100 visits and three or less yearly visits as well as to identify factors that contribute to the overutilization of non-emergency and ongoing services with its effect on value-based reimbursement and post ED strategies resulting in quality enhancement for uninsured Hispanics.

Summary of Evidence

Being Hispanic, uninsured, residing within a non-expansion Medicaid state, younger adult and women with limited English proficiency, and accessing care at a nonparticipating value-based care program has proven to directly affect healthcare utilization rates in the ED for non-emergency conditions such as ongoing medical problems. EMTALA legally influences hospitals to provide medical care to any patient regardless of insurance status, which has resulted in the increase demand for healthcare services in the ED including primary care services and non-emergency medical care. In non-expansion Medicaid states, it has been demonstrated that Hispanics who do not qualify for this government program nor are able to afford insurance coverage receive care from low-quality facilities, have unmet medical needs, delay in medical care, suffer from multiple chronic conditions, have low levels of medication adherence, longer

hospital stays, and higher risk of self-pay and do not have a usual source of medical care. Uninsured Hispanics experience difficulties when accessing other courses of medical care, resulting in the overutilization of healthcare services in the ED for non-emergency conditions and ongoing medical conditions leading to the potential impact on the quality of health and most importantly, in the overall well-being of individuals.

Purpose of the Integrative Review

According to Dhollande et al. (2021), an integrative review is a rigorous process in which all existing knowledge, including qualitative and quantitative research, is analyzed allowing for a complete evaluation of the quality of the evidence, identifying gaps within the research, developing research questions, and most importantly, describing the theoretical framework. These authors also specified that an integrative review is utilized by healthcare professionals to analyze the accessible evidence and apply it to clinical practice as well as healthcare policymakers to make informed decisions for patient oriented and reliable results (Dhollande et al., 2021). In this study, the methodological process included the following: healthcare administration and operation problem identification, literature research, evaluation of data, analysis of the searched data, and a complete synthesis of the findings. There are two purposes to this integrative review: (a) to search the existing body of knowledge related to hospital utilization rates, for non-emergency conditions, and quality of health; and (b) to provide strategies for leaders to reduce healthcare utilization rates in the ED for uninsured Hispanics.

Integrative Review Question

What are the best practices for improving healthcare utilization rates in the ED and potential consequences on the quality of health for uninsured Hispanics?

Theoretical and/or Conceptual Framework

The conceptual framework used in this study was Donabedian's (1988) structure, process, and outcome (SPO) model. According to Ayanian and Markel (2016), the Donabedian SPO model is a useful metric to use when obtaining samples for measurements and standards resulting in the assessment of quality of care. The first measurement is structure, which can be defined as the healthcare setting including administrative systems and providers qualifications. The second measurement is process, which explains how the healthcare system works to deliver care. The third measurement is outcome, which is the restoration of function and survival for patients (Ayanian & Markel, 2016). Pertaining to the current study, the structure is the healthcare facility (e.g., ED), the process includes the delivery of healthcare services (e.g., non-emergency conditions in the ED), and the outcome is the quality of health for uninsured Hispanics.

Donabedian (1988) explained how the SOP model is useful when assessing quality because it establishes how healthcare facilities need to be organized, have adequate sampling of the population, and have structure resulting in good healthcare processes for patients. This approach is used by healthcare facilities and government agencies such as Centers for Medicaid and Medicaid Services (CMS). The CMS (2021) uses quality improvements and measures to enhance healthcare outcomes for patients by identifying gaps within the population and the healthcare system and by implementing outcome-based measures. According to Backhouse and Ogunlayi (2020), quality improvement serves as the foundation to improve every aspect of the healthcare system by planning the needed change, by measuring the results of the change, and by adapting the change within the facilities. The Donabedian SOP model was the appropriate

conceptual framework for this study because its purpose is to explain the association between the utilization of healthcare services in the ED and quality of health for uninsured Hispanics.

Part 2: Literature Review, Quality Appraisal, and Analysis

Literature Search Strategy

An integrative review of existing knowledge was completed for years 2020–2024. The following databases were included in the integrative review: ProQuest, CINAHL & MEDLINE Combined Search, ScienceDirect, Emerald Insight, and JAMA Network Open. Hand searching, forward and backward, of reference lists resulted in positive results in Google Scholar. Key search words included *uninsured, no insurance, emergency room, emergency department, emergency services, utilization rates, Hispanic, Latin*, nonurgent, non-emergency, measurement of quality, value-based healthcare, value-based care, value-based healthcare, reimbursement, payment, insurance, Medicaid expansion, Affordable Care Act*, and *non-expansion Medicaid*. All key words were utilized across the databases and were combined by utilizing AND. To further complete the integrative review, inclusion and exclusion criteria were included as shown in Table 1. In this study, the target population was uninsured Hispanics and articles were further reviewed and accepted if they described either/or uninsured, no insurance, ED utilization, non-emergency, and Hispanic or Latin*.

Table 1

Inclusion and Exclusion Search Criteria

Inclusion search criteria	Exclusion search criteria
English language	Hospitalization/Tertiary care
2020–2024	Other hospital departments
Uninsured Hispanics	Private and Medicaid/Medicare
Issued emergency department utilization	Emergency medical conditions
Value-based care/healthcare	Other racial/ethnic groups
Non-expansion Medicaid	Vaccines
Non-emergency/non-urgent conditions	

A total of 441 articles were reviewed. Through hand searching forward and backward of reference lists, four articles were identified for revision. A total of 27 articles were removed due to focusing on Medicaid/Medicare, third level of medical care, medical studies, COVID-19, and opioid substances. Once this process was complete, 418 articles were analyzed via titles, abstracts, and keywords using the inclusion and exclusion criteria. Then, 378 articles were excluded resulting in 40 articles for further analysis. After full-text review, nine articles were removed due to not focusing entirely on uninsured Hispanics, emergency utilization rate, quality of care, and non-emergency visits. See Appendix B for additional search results information.

Quality Appraisal

A total of 31 articles were included for the literature quality appraisals analysis. All 31 articles were appraised for quality using the John Hopkins nursing evidence-based practice including research and non-research evidence appraisal form (Dang et al., 2022). Using this tool, I rated four articles as having a strength of evidence Level I, eight articles as having a strength of evidence Level II, eight articles as having a strength of evidence Level III, and 11 articles as having a strength of evidence Level V. Out of the total 31 articles selected for review, 26 were appraised as a high quality and five were appraised as good quality. For additional details on quality appraisal for the reviewed articles, see Appendix C.

Thematic Analysis of Literature

Most of the selected articles for appraisal were retrospective review cross-sectional surveys, including telephone-based and in-person questionnaires, expert opinion, literature and integrative review, qualitative descriptive design, and quantitative

studies. Authors provided information on how to reduce bias by using coding to breakdown participants' narratives, by discussing the teams within the research team, by testing the validity of the data using different screening criteria, and in-depth evaluation and collection of data from different sources (Ayon et al., 2020; Bornais et al., 2020; Choi et al., 2020; Escobedo et al., 2023; Ramirez et al., 2020). Authors further explained study limitations that included cultural beliefs and perspective differences across the Hispanic population, single center studies and concerns with lack of generalization within the population, open-ended questionnaires, and insufficient participant perception of ED access for non-urgent services, cross-sectional data and limited longitudinal analysis without social economic information of Hispanics preventing causality between the variables, and sample size with its influence on non-response bias.

Part 3: Presentation of Results

The thematic analysis was completed on the 31 articles, which resulted in four major themes and 12 subthemes. From the 31 articles analyzed, codes were identified and aligned with Donabedian's SPO model and subthemes were categorized according to their relationship with the four major themes. The research question was: What are the best practices for improving healthcare utilization rates in the ED and potential consequences on the quality of health for uninsured Hispanics? This question was examined for emerging themes. For the full thematic analysis results see Appendix D.

Results

The following are example codes for the articles included in the thematic analysis matrix (Appendix D):

- *Uninsured Hispanics*: Mostly female, high use of ED services, increased ED utilization rates, do not have a primary care provider, living below the poverty line even after being employed, highest uninsured rate in the United States, and limited English proficiency when seeking medical care and use of proxy.
- *Non-emergency ED visits*: Overutilization of ED services and for non-emergency conditions, use of primary care services, ongoing medical conditions, medical debt, and lack of reporting for new medical conditions.
- *Delay in healthcare services*: Medical complications, not having a usual source of medical care, high medical charges in the ED, postponing medical care due to costs, increased risk for chronic conditions such as asthma, hypertension, and diabetes, and overdue for preventive visits.

After determining the codes that were extracted from the 31 articles, four themes were further analyzed and related to Donabedian's SPO model. The four themes are (a) insurance coverage, (b) high-risk uninsured patients, (c) ED, and (d) healthcare payment models. Subthemes are listed and further explained below the main four themes. To view the thematic map, see Appendix E. Under the first theme, insurance coverage, there were three subthemes:

- Non-expansion Medicaid states: Expanding Medicaid coverage in the remaining 10 states would improve health disparities and outcomes for the uninsured.
- Delay in healthcare services: Discharge programs to transition patients from the ED to primary and non-acute care to reduce utilization rates and improve quality and value.
- Financial barriers: Collaborative work to identify financial barriers and provide outpatient services within the community to decrease ED overuse.

Under the second theme, high-risk uninsured patients, there were two subthemes:

- Chronic conditions: Initiatives aimed at educating and providing resources at patients' postdischarge to enhance coordinated care and reduce ED visits.
- Medication costs and adherence: Incorporating a postdischarge intervention program by providing medical care and medication assistance to prevent unplanned ED visits.

Under the third theme, emergency department, there were five subthemes:

- Emergency Medical Treatment and Labor Act (EMTALA): Quality-improvement and postdischarge programs to transfer patients to other healthcare facilities by

ensuring decrease in ED return visits and increase utilization in outpatient services.

- Frequent and treat-and-release visits: Value-based approaches in delivering care, supporting clinician–patient relationships and collaborative healthcare services postdischarge to reduce ED visits and enhance outpatient care.
- Healthcare costs: Continued efforts for insurance coverage expansion and providing care for unexpected health emergencies to improve quality of care and delivery of healthcare services.
- Primary care services and accessibility: Engaging community-based healthcare providers and EDs to transition patients to primary care services and reduce avoidable ED visits.
- Healthcare quality: Value-based strategies to measure costs and health outcomes of patients for quality improvement and preventing unnecessary ED visits.

Under the fourth theme, healthcare payment models, there were two subthemes:

- Fee-for-service model: Changes in healthcare payment models that focuses on quality assurance for improving patient health outcomes.
- Value-based reimbursement strategies: Connecting EDs with value-based care and ensuring quality of care to manage costs and avoid repeated ED visits.

Interpretation of the Findings

Theme: Insurance Coverage

This theme embodies the direct effect insurance coverage has on healthcare access as well as strategies to reduce ED utilization by improving postdischarge and transitional care programs for uninsured Hispanics. Insurance coverage is part of the

process in the Donabedian SPO model because it connects the structure (ED) with the desired outcome (quality of health) because insurance status can determine how patients' access healthcare services. Identifying healthcare barriers patients experience when accessing care allows ED programs to make connections and provide appropriate support to underprivileged populations (Jiang et al., 2022), including unemployed, low-income, and uninsured Hispanics (Al Rifai et al., 2021). The subthemes are non-expansion Medicaid states, delay in healthcare services, and financial barriers.

Subtheme: Non-Expansion Medicaid States

According to Levitt (2021), for the states that have not adopted Medicaid expansion, the federal government has provided a solution that will cover 90% of the healthcare costs and there is an additional 2-year fiscal incentive for states that start the expansion process. The 10 states that have not adopted Medicaid expansion are Alabama, Tennessee, Texas, Florida, Georgia, Kansas, Mississippi, South Carolina, Wisconsin, and Wyoming (Drake et al., 2024). If the remaining 10 states adopt Medicaid expansion, the 1.5 million adults in the coverage gap will gain insurance coverage (Drake et al., 2024), and studies have demonstrated a significant reduction in uninsured risk for people in lower socioeconomic status (Lee et al., 2021; Lin et al., 2021). This recommended solution for Medicaid expansion will positively improve health outcomes and access to care (Drake et al., 2024) and lower the rates of difficulties in accessing care (Al Rifai et al., 2021). While at the uninsured level, insurance expansion for Hispanic adults will reduce disparities in care for those who have more chronic health problems and likely experience financial barriers (Choi et al., 2020).

Subtheme: Delay in Healthcare Services

In a hospital-level study, Biese et al. (2022) found that unnecessary ED visits can be prevented by implementing transitional care such as callback programs. Upon ED discharge, patients receive an automated call including discharge instructions, option for provider call follow-up, and assistance in scheduling appointments, a solution to address the delay in healthcare services (Biese et al., 2022). The postdischarge approach is particularly important because it can benefit Hispanic patients who tend to access the ED for ongoing medical care of chronic conditions (Cobb et al., 2022; Ramirez et al., 2022). The strategy behind this program is to transition patients to primary and non-acute care after ED discharge, encouraging integrated medical care at a system level to improve quality and value (Biese et al., 2022) and, most importantly, to decrease ED return visits by socially disadvantaged populations including uninsured and low-income patients by increasing outpatient care (Jiang et al., 2022; Ukert & Giannouchos, 2023).

Subtheme: Financial Barriers

Jiang et al. (2022) provided insight into community health initiatives on financial barriers and healthcare services utilization. They found that community health workers can assist in closing the gaps in post-ED care by identifying financial limitations, such as insurance status, that disrupt outpatient healthcare access (Jiang et al., 2022). Within this initiative, exploring underutilized services within the community will allow for patients to be directed to these outpatient facilities for nonurgent services instead of the ED (Bornais et al., 2020). Working in collaboration with community-based organizations will prevent patients to experience financial barriers when accessing healthcare services (Ayon et al., 2020) and availability of language-concordant care (Escobedo et al., 2023;

Ramirez et al., 2022). This ensures optimal patient–provider communication (Ayon et al., 2020) and emphasizes how removing financial barriers and improving health outcomes can be accomplished by insurance expansion (McMaughan et al., 2020). Supporting patients in providing healthcare resources will increase the use of outpatient services (Jiang et al., 2022), will gain patient trust in receiving appropriate care within the community, and may alleviate the pressure of ED overuse (Bornais et al., 2020).

Theme: High-Risk Uninsured Patients

This theme represents how lack of healthcare access such as primary care services, living below the poverty line, being unemployed, affordability of prescriptions, and insurance status does have a direct effect on being a high-risk patient with multiple chronic health conditions.

Proposed solutions to decrease ED utilization by uninsured Hispanic patients include post-ED programs and value-based strategies at a hospital and community level.

Evaluating the causes of difficulty when it comes for high-risk patients to access medical care is important to guarantee timely delivery of services (Al Rifai et al., 2021). The sub-themes are chronic conditions and medication costs and adherence.

Subtheme: Chronic Conditions

Al Rifai et al. (2021) explored initiatives that can address barriers when accessing healthcare services for chronic condition patients since reports have shown how Hispanics experience healthcare barriers leading to low levels of access to timely services (Cobb et al., 2022). In this study, providing reliable contact information in a clinic and transportation to appointments does provide adequate and timely access to healthcare services for chronic condition patients (Al Rifai et al., 2021). Another health initiative

may include the referral to post-discharge programs, such as patient navigator, for uninsured and high-risk patients. The objective of this program is to ensure coordinated medical care for patients who have difficulties in scheduling healthcare appointments after ED discharge and provides education when it comes to accessing the healthcare system (Jiang et al., 2022). These initiatives empower uninsured and chronic condition patients to successfully navigate the healthcare system, but most importantly, reduce ED utilization through post-ED programs (Jiang et al., 2022).

Subtheme: Medication Costs and Adherence

Previous studies have mentioned how medication nonadherence for chronic conditions is directly influenced by experiencing financial burden due to prescription drug costs (Han et al., 2020; Lago-Hernandez et al., 2021), which is why Biese et al., (2022) proposes a solution for unplanned care in the ED including assistance in obtaining medications. The research found how patients who reported unplanned ED visits are to be enrolled in an intervention program that will permit for healthcare professionals to identify what is needed to assist patients upon discharge such as providing prescribed medications (Biese et al., 2022). This program helps patients receive the needed medical care and additional services after ED discharge by emphasizing the importance of providing high-value care, managing costs and preventing unplanned ED visits (Biese et al., 2022).

Theme: Emergency Department

This theme describes the association between the availability of primary care services and frequent ED visits with its impact on healthcare costs and quality for uninsured Hispanics. Practices that address the ED utilization rate and prioritize quality

of care (da Silva Etges et al., 2023) are to be centered around patient coordinated medical care and value-based models' post-discharge (Biese et al., 2022).

ED is part of the structure as well as process in Donabedian SPO model because the structure is considered the ED, and process is the delivery of healthcare services including non-emergency conditions. The subthemes are EMTALA, frequent and treat-and-release visits, healthcare costs, primary care services and accessibility, healthcare quality.

Subtheme: Emergency Medical Treatment and Labor Act

Hsuan (2023) provided insight into patient-centered quality and policy programs that monitor transferred patients from the ED to other healthcare facilities for continuity of care. It's imperative to mention how EMTALA discourages the practice of dumping uninsured patients (Shenoy et al., 2022; Kraus et al., 2020) and doesn't apply once a patient has been medically stabilized which is why coordination between healthcare facilities is to be improved by quality-improvement programs and payments are to be based on the care provided to patients throughout the duration of medical care (Hsuan, 2023). Relative to this, Jiang et al. (2022) explored the impact post-discharge transfer programs have on ED return visits by the uninsured. The study emphasized how prior to post-discharge for uninsured patients, a medical team will further assess and identify additional needs and barriers the patients might be experiencing including appointment scheduling and referrals to other healthcare facilities (Jiang et al., 2022). Successfully transferring patients from the ED to other healthcare facilities and providing resources such as referrals and appointment scheduling, will improve utilization of outpatient services and reduce ED return visits by the uninsured (Jiang et al., 2022).

Subtheme: Frequent and Treat-and-Release Visits

The time-consuming health concerns cannot be properly addressed in a fast-paced environment which is why collaborative change is needed to facilitate solutions that will cover the needs of complex patients outside of the ED (Cronin et al., 2020) due to overutilization in treat-and-release visits for uninsured Hispanics (Scott et al., 2021).

A study by Teisberg et al. (2020), proposes organizing teams that will manage care for patients with similar healthcare needs by following value-based approaches and delivering care will be placed in the hands of medical teams rather than insurance administrators. Organizing care will allow for the medical team to foresee patients' medical needs and resourcefully provide the healthcare services especially for patients who need additional care (Teisberg et al., 2020). This strategy supports clinician-patient relationships to deliver effective care within the ED and coordinated care post-discharge which can be accomplished by incorporating other clinical organizations to expand and improve care (Teisberg et al., 2020). This solution centers on providing post-discharge follow-up care which focuses on high-continuity outpatient care and reduces ED return visits (Jiang et al., 2022).

Subtheme: Healthcare Costs

Healthcare costs factor into decisions about insurance coverage and care seeking, which can affect uninsured adults such as those experiencing financial uncertainties (Lopes et al., 2024). Scott et al. (2021) provided insight into a cost strategy that will benefit uninsured patients and unscheduled care in the ED. The study described how expanding meaningful insurance coverage for unexpected health problems by bolstering state or federal incentives to curb charges, mitigating financial collection practices, and

further evaluating payment structures will guarantee EDs are effectively compensated for the delivery of healthcare services in the community (Scott et al., 2021) and healthcare expenses can be reduced by early interventions of disease prevention for the uninsured (Zhang & Wu, 2021). This cost strategy is useful for medical teams in the ED since it identifies areas needing change when delivering healthcare services to patients with frequent medical needs by improving quality which is the focus of value-based health care (Teisberg et al., 2020) and guarantees that uninsured patients are not at undue risk of financial harm by seeking healthcare services (Scott et al., 2021).

Subtheme: Primary Care Services and Accessibility

Jiang et al. (2022) explored the impact post-ED programs such as patient navigator has on timely outpatient care, primary care services and return ED visits. Through the authors research, they found how patients who reported barriers when accessing care outside of the ED, are to be linked with community-based healthcare providers by assisting in appointment scheduling for primary care and outpatient services (Jiang et al., 2022). Reports demonstrate how the use of EDs for primary care services has been proven to compromise the efficiency of the ED in providing emergency care (Bornais et al., 2020) and contribute to health disadvantages among Hispanics (Oh et al., 2020; Parast et al., 2021). Which is why collaborative work between the ED and community-based healthcare providers demonstrates the effectiveness of patient navigator initiatives in the community which helps decrease avoidable ED visits and improves quality of care (Jiang et al., 2022). This program is important for uninsured patients who need assistance on how to navigate the healthcare system resulting in

connections to insurance resources and primary care follow-up appointment adherence (Jiang et al., 2022).

Subtheme: Healthcare Quality

Promoting high-quality care by quality improvement is to restructure current healthcare processes that will result in better patient outcomes (Hannawa et al., 2022). Healthcare quality is the outcome in the Donabedian SPO model. It is a combination of care processes such as rapid recovery, family engagement, trust, patient compliance, high efficiency, and system adjustments as well as good results related to the overall healthcare system (Hannawa et al., 2022). Teisberg et al. (2020) explored the importance of value-based approach and measuring health outcomes on quality improvement for chronic conditions. Through the research, the authors explained how medical teams who oversee the delivery of healthcare services for patients with chronic conditions must measure health outcomes and costs since this will determine the areas needing quality improvement for delivering care per each patient (Teisberg et al., 2020). This demonstrates how aligning quality improvement with value-based healthcare leads to coordinated care for disadvantaged populations by preventing unnecessary ED visits (Biese et al., 2022) including single diagnosis and routine examination (Alnasser et al., 2023). Enhancing patient outcomes is the major objective for quality assurance and changes of healthcare processes (MacGillivray, 2020).

Theme: Healthcare Payment Models

The United States healthcare system has two healthcare payment models: first, fee-for- service model is when healthcare providers receive higher reimbursements for more tests, procedures and hospitalizations (MacGillivray, 2020) and second, value-based

focuses on quality of care since such payment model emphasizes the importance of delivering better services without increasing costs (de Silva Etges et al., 2023). In the Donabedian SPO model, healthcare payment models are both the structure and process within the healthcare system because according to the type of payment model that a healthcare facility follows will determine the outcome of quality of care and services. High-quality care is to be prioritized by redesigning system processes that will optimize good quality perceptions such as fluid care processes (Hannawa et al., 2022). The sub-themes are fee-for-service model and value-based reimbursement strategies.

Subtheme: Fee-for-Service Model

MacGillivray (2020) emphasized how fee-for-service is being reformed into a value- based model and healthcare quality can be improved by the following aims: patient safety, effective and informed medical decisions, patient centered and holistic approaches, avoid unnecessary medical delays, and equal healthcare access. Research findings explain how improvement in the healthcare payment model will demand quality assurance, a culture of safety and implementation of systems of care to enhance healthcare quality (MacGillivray, 2020). This author proposes that instead of only focusing on healthcare costs while trying to manage quality simultaneously, it's better to focus on improving quality, which will eventually decrease costs (MacGillivray, 2020) by structuring care and designing comprehensive solutions around patients' medical needs such as chronic conditions, will allow for healthcare professionals to provide the frequent needed care to enhance patient outcomes (Teisberg et al., 2020).

Subtheme: Value-Based Reimbursement Strategies

A study by de Silva Etges et al. (2023) explored how value-based reimbursement strategies is the alternative that will align the patient, healthcare facility and payer. The research found how value-based strategies and accurately measuring costs prior to adjusting providers fees which also includes patient-level costs and outcome information, promote a more sustainable healthcare system while focusing on improving health and value (de Silva Etges et al., 2023). This study demonstrates how ensuring quality of care, preventing unnecessary ED revisits by frequent users such as underserved patients, and managing healthcare costs, can be accomplished by aligning EDs with value-based care strategies that will transition these patients to primary, nonacute and long-term medical care (Biese et al., 2022). The net result will be helping patients obtain the care they need which avoids frequent and repeated ED visits by encouraging high-value and integrated care (Biese et al., 2022).

Part 4: Recommendation for Professional Practice and Implications for Social Change

Recommendations for Professional Practice

Donabedian's SPO Model

The foundation of this integrative review focused on Donabedian's (1988) structure, process, and outcome (SPO) model. Structure is the setting in which care has occurred, process is the action being delivered in giving and receiving care such as patients accessing care and delivery of treatment, and outcome is the effect of care on a patient's health status (Donabedian, 1988). Consequently, the ED (access and delivery of non-emergency services) and healthcare payment models (fee-for-service and value-based) are part of Donabedian's structure and process. Insurance coverage is part of Donabedian's process since this determines how patient's access healthcare services in the ED and connects the structure (ED) with the expected outcome, which is quality of health for uninsured Hispanics.

Within this review, evidence demonstrated how uninsured Hispanics who lack a usual source of medical care, access the ED for non-urgent conditions (Parast et al., 2021) including routine examination/primary care services, lab work, fatigue, medication refills, and wound care (Alnasser et al., 2023). Such availability has permitted for patients to access the ED since EMTALA guarantees delivery of healthcare services regardless of affordability and insurance status (Shenoy et al., 2022) which is why uninsured patients are medically dependent on the ED (Scott et al., 2021) due to not having access to comprehensive primary care in the community (Bornais et al., 2020). As a result, it is imperative to align and implement the ED with post-ED and value-based care programs

which maintain healthcare costs, improves quality care and most importantly, guarantees the prevention of unnecessary ED visits (Biese et al., 2022).

Value-Based Strategies

As previously mentioned, fee-for-service care emphasizes in higher reimbursements for providers who do more tests, procedures, and hospitalizations (MacGillivray, 2020) without any consideration for patient outcomes resulting in a change in value by delivering better outcomes and a sustainable healthcare system through value-based strategies (de Silva Etges et al., 2023). Teisberg et al. (2020) explained how value in healthcare can be achieved by measuring the improvement in a person's health outcomes and the cost for achieving such improvement through five strategic frameworks (Figure 1).

The first strategy is to understand shared health needs of patients. In this strategy, the healthcare facility selects a dedicated, co-located and multidisciplinary medical team that will identify patients whose health has created a recurring set of medical needs. (Teisberg et al., 2020). Uninsured females who are frequent ED users (Cronin et al., 2020), younger Hispanics and millennials, ages 23-38 who suffer from health disparities (Zambrana et al., 2021), uninsured Hispanics with multiple chronic conditions who experience medication affordability issues (Lopes et al., 2024) resulting in medication nonadherence (Han et al., 2020), undocumented immigrants from Hispanic origin who receive less medical care (Ayón et al., 2020), due to limited English proficiency and absence of health insurance coverage (Ramirez et al., 2022), are examples of patients needing recurring medical care. This integrated medical team measures health outcomes, and the costs associated with providing care allowing improvement in care and for the

healthcare facility to be the organizer of coordinated services (Teisberg et al., 2020). Inability to structure around patients' medical needs and for routine care results in a lack of integrated services which increases the burden on healthcare professionals to improvise due to structural mismatch when providing healthcare services (Teisberg et al., 2020).

Once the medical team identifies the healthcare needs, the second strategy is to design solutions to improve health outcomes. In this strategy, the medical team will design and deliver care that will emphasize on solving the needs of patients by addressing obstacles that influence nonclinical and clinical needs by integrating learning teams (Teisberg et al., 2020). Examples of obstacles that cause delay in accessing healthcare services are transportation and language.

According to Al Rifai et al. (2021), high-risk patients with chronic conditions do require longitudinal access to healthcare services and providing transportation and/or fare to appointments, can enhance the access to healthcare. Hispanic adults with limited English proficiency report disparities when accessing healthcare services (Oh et al., 2020) resulting in perception of poor medical care which can be changed by having bilingual clinicians and in- person Spanish interpreters (Escobedo et al., 2023). In this third strategy, integrating co-located medical and nonmedical teams will enable frequent communication to improve, allowing for personalized care to be created and enhanced over time (Teisberg et al., 2020). Such enhancement of care will be expanded across locations making it easier for patients to obtain care locally and without traveling (Teisberg et al., 2020).

The fourth strategy emphasizes on measuring health outcomes and cost for delivering care since it provides the needed data to understand how to improve care and efficiency (Teisberg et al., 2020). This strategy can be accomplished by Donabedian's three-approach (SPO model) to quality assessment because having good structure increases the likelihood of a good process resulting in good outcomes (Donabedian, 1988). The fifth strategy focuses on expanding partnerships amongst clinical organizations to work on different stages of care resulting in better patient outcomes (Teisberg et al., 2020). An example of such expansion is follow-up after ED discharge and provide care coordination to reduce avoidable and return ED visits causing improvements in health outcomes (Jiang et al., 2022).

Structuring care around patients' medical needs allow for healthcare teams to consistently anticipate, organize and personalize healthcare services resulting in the delivery of coordinated care and high value. (Teisberg et al., 2020).

Figure 1

Strategic Framework for Value-Based Health Care Implementation to Achieve Better Patient Outcomes

Source. From "Defining and implementing value-based health care: A strategic framework," by Teisberg, E., Wallace, S., & O'Hara, S., 2020, *Academic Medicine, 95*(5), 682–685. https://doi.org/10.1097/acm.0000000000003122

Post-ED Programs

In addition to the five strategic frameworks by Teisberg et al. (2020) and Donabedian's three-approach (SPO model) for quality assessment, post-ED programs serve as interventions to reduce preventable and non-emergency visits by providing timely outpatient care (Jiang et al., 2022). Quality improvement call back program is an example of post-ED strategy provided to patients who speak a language other than English, to prevent unnecessary ED revisits, manage cost, and improve the value of care (Biese et al., 2022). In this program, two days after ED discharge, patients receive an automated call to know if there are any questions regarding discharge instructions and if a follow-up call is needed from a clinician such as nurse practitioner and physician

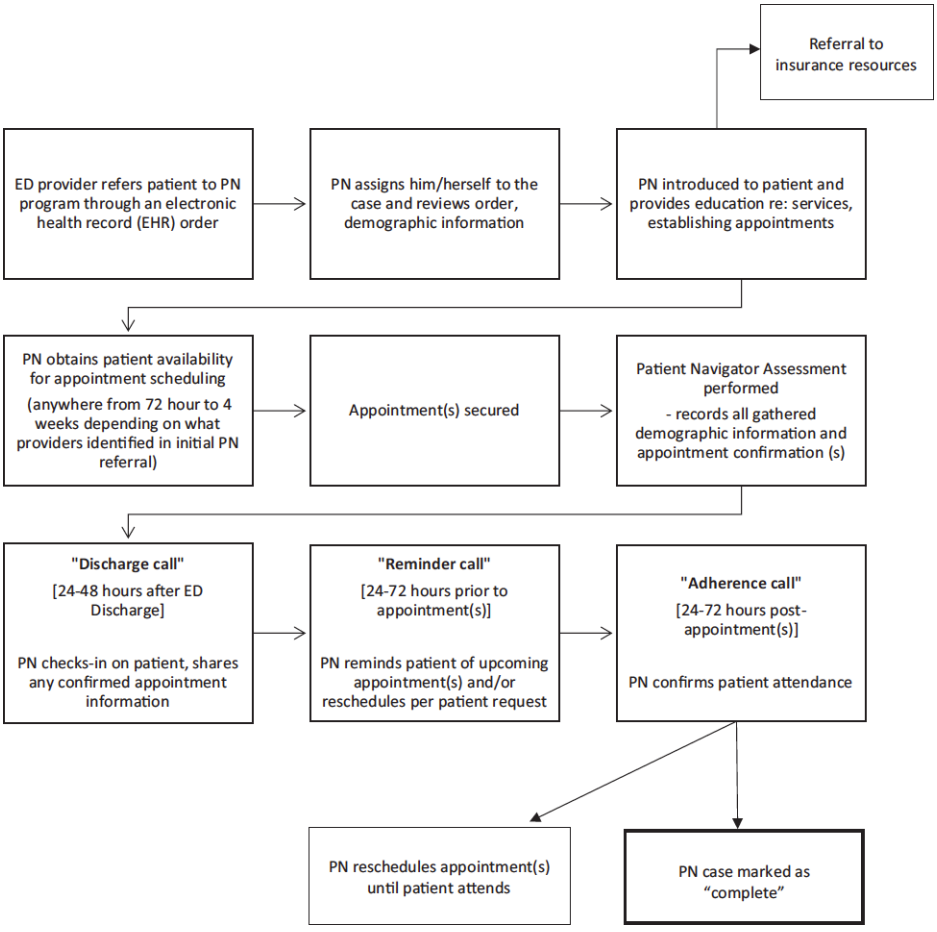
assistant. Patients who select the follow-up call option, can be assisted with medical care and discharge plan questions as well as scheduling follow-up appointments and obtaining medication prescriptions (Biese et al., 2022). This quality improvement call back program is aligned with value-based care model permitting for disadvantaged populations who are frequent ED users to be transitioned to primary care clinicians and nonacute care after ED discharge (Biese et al., 2022). Disadvantaged populations such as uninsured Hispanics, residing in non-expansion Medicaid states, and who reported use of the ED for healthcare services because of less access to insurance coverage (Drake et al., 2024) can be benefit from this program resulting in improved healthcare equity and avoiding repeated ED visits (Biese et al., 2022).

The Patient Navigator (PN) Program is another example of post-ED strategy to support vulnerable populations including uninsured, younger age, low-income patients, and ethnic minorities, who frequent the ED due to experiencing difficulties when accessing care post-discharge (Jiang et al., 2022). This program aids uninsured patients on how to navigate the healthcare system by making connections to medical care (Jiang et al., 2022). Once a patient has been discharged from the ED, the designated hospital team, identify patients who need assistance with scheduling medical appointments and if the patients fall under the following criteria: lack of access to primary care and insurance, failed attempts to schedule follow-up appointments, and prior ED use for low levels of care, then this hospital team provide referrals to the program (Jiang et al., 2022). Uninsured patients under this program are interviewed by navigators who will then identify the healthcare barriers and schedule outpatient appointments such as primary care visits and refer to insurance resources (Jiang et al., 2022). Navigators will then

collect information regarding the patient's demographic, adherence on outpatient appointments and will continue to follow-up until care completion, which then are removed from the worklist (Jiang et al., 2022). Implementing changes to the structure and process of healthcare services will allow for improvement in patient's knowledge and health status (Donabedian, 1988).

Figure 2

Flow of PN Intervention After Patient Referral



Source. From "Emergency department patient navigator program demonstrates reduction in emergency department return visits and increase in follow-up appointment adherence," by Jiang, L. G., Zhang, Y., Greca, E., Bodnar, D., Gogia, K., Wang, Y., Peretz, P., &

Steel, P. A. D., 2022, *The American Journal of Emergency Medicine, 53*, 173–179. https://doi.org/10.1016/j.ajem.2022.01.009

Implications for Social Change

Within the United States healthcare system, the ED utilization for non-emergency and ongoing services is continuously increasing resulting in a reform on payment models from fee-for-service to value-based reimbursement strategies with its focus on cost, value of care and coordinated medical care post ED discharge. To further explain this healthcare concern, changes within the Hispanic population including demographic, insurance status, and living in non-Medicaid expansion states, have directly influenced the utilization of healthcare services resulting in delay to access to care such as primary care services. A focus on the four major themes and 12 subthemes of this integrative review and alignment with Donabedian's SPO model, will have a positive impact on healthcare utilization rates in the ED and influence on the quality of health for uninsured Hispanics.

Limitations

This integrative review was focused on the healthcare utilization rate in the ED and quality of health for uninsured Hispanics through value-based strategies and post-ED programs aligning Donabedian's SPO model which provides a systematic approach for healthcare administrators and community leaders to utilize and enhance processes that will positively impact the quality of healthcare services and patient outcomes. This integrative review did not explore other issues that impact the health of uninsured Hispanics such as changes in immigration laws and per state since this area of concern is

expected to be discussed when analyzing insurance status and when using the Donabedian's SPO model.

Conclusion

The United States healthcare system is facing the challenge of ED overutilization for non-emergency and ongoing services by uninsured and high-risk Hispanics. Value-based strategies and both post-ED programs, quality improvement call back and Patient Navigator, can influence the decrease in ED visits by providing continuity and coordinated medical care to high-risk Hispanic patients who are uninsured, experience delay in healthcare services and reside in non-Medicaid expansion states. This integrative review provides strong evidence that Donabedian's SPO model offers an efficient framework for changes in the structure and process within the ED resulting quality assurance and enhancement in patient health outcomes.

Aligning the four themes with Donabedian's SPO model can be used as a framework to develop and implement strategies that support patients upon ED discharge by scheduling appointments and providing follow-up for adherence at primary care and outpatient care services. Donabedian's SPO model allows for quality of healthcare to be evaluated including the assessment of medical prevention, rehabilitation, coordination, continuity of care, and patient-physician relationship as well as influenced value-based payment and patient- centered outcomes (Ayanian & Markel, 2016).

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Appendix A: DHA Practice-Based Problem Literature Review Matrix

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Agency for Healthcare Research and Quality. (2017)	N/A	A portion of the patients do return to the ED frequently and account for a large share of nonurgent visits.	N/A	Across three hospitals, between 2014- 2015, the team identified 386 patients who, based on their medical records, met at least one of the criteria for frequent ED use. The criteria was: Four or more prior visits in the previous 12 months or three or more prior visits in the previous 3 months or one or more prior visit in the previous 72 hours.	According to this agency, the participants in this study was labeled as high-frequent users of the emergency department. 56% did not understand discharge instructions, 14.3% reported not having a primary care provider, 6.7% were uninsured, 48.7% did not have medication adherence, and 39.6% didn't understand which symptoms do require immediate medical attention.	Additional search is to be completed in emergency departments across the country to determine if there have been any changes in the ED utilization rate for uninsured patients and if such changes do continue to influence lack of medication adherence, symptom recognition and use of primary care services.	At practice, healthcare searches alongside with healthcare administrators should analyze the frequency patients obtain healthcare services from the emergency department permitting for post-release coordination of care to be implemented for high-risk and high-frequent ED users.	No

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Alnasser, S., Alharbi, M., AAlibrahim , A., Aal ibrahim, A., Kentab, O., Alassaf, W., & Aljahany, M. (2023)	Andersen Behavioral Model	Inappropriate use of the emergency room and for non-emergency conditions, does reduce the quality of patient care and increases the risk of adverse medical outcomes.	Retrospective review	Data was obtained from the Emergency Department at King Abdullah Bin Abdul-Aziz University Hospital from July 2020 to July 2021. Patients with a Canadian Triage and Acuity Scale of 4 or 5 were included in the study and, those who needed medical evaluation/stabili zation/treatment for emergent/urgent/ less urgent/non- urgent conditions were included as well.	The authors reported that for non-emergency visits to the emergency room were prescription medications (94.2%), performing laboratory tests (62.8%), obtaining sick leave (4.7%), performing a radiology examination (3.6%), visiting PHCCs (family medicine) within a week of the emergency visit (3.6%), upper-respiratory infections/sympt oms (9.9%), skin and allergic problems (4.8%), ear, nose, and throat infection/proble ms (3.6%); headaches and migraines (3.3%), musculoskeletal/ joint pain and bone fractures (3.2%), injury, trauma, and falls (2.3%), other infections (2.3%), and eye problems (2.1%). In this study, 61.4% of patients who visited the emergency room were for non- emergency or less-urgent cases.	Additional research must be conducted within hospitals across the United States allowing for there to be a deeper understanding on the reasons why patients utilize the emergency room for non- emergency conditions and its impact on the quality of health.	This study should be utilized in other healthcare facilities allowing for there to be a comparison in the utilization of healthcare services in the emergency room allowing for healthcare administrators to efficiently allocate resources that will help in the reduction of the use of the emergency room for non- emergency conditions.	Yes

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Ayanian, J. Z., & Markel, H. (2016)	Donabedian SPO model	Social and economic research on health does have an influence on public health, organization of the community, health agencies, and the quality of health services.	N/A	N/A	The authors reported how the quality of health can be evaluated by the structure, which is the healthcare setting, the process which is the components of delivered care and the outcomes which is the recovery.	Further research is needed to comprehend how changes within the social and economic does have a direct influence on the healthcare system.	Improving structure and process of the healthcare system regarding insurance coverage will enhance quality of care which is considered the outcome.	No
Backhouse, A., & Ogunlayi, F. (2020)	Donabedian SPO model	Healthcare professionals that are involved in quality improvement activities do assist with delivery change in the healthcare setting as well as improving patient care.	N/A	N/A	According to the authors, quality improvement serves as the foundation to improve serves as the foundation to improve every aspect of the healthcare system by planning the needed change, by measuring the results of the change, and by adapting the change within the facilities.	Additional research will have to be completed on how quality improvement can be furthered utilized in the delivery of healthcare services through the continuous changes in the delivery of care and redesigning processes and systems that will enhance patient care.	Quality improvement should be implemented in all healthcare facilities allowing for there to be systematic changes in patient safety, care, and delivery of healthcare services.	No

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Cronin, A. O., Morton, D. J., Brennan, J. J., & Castillo, E. M. (2020)	Health services research theory	There has been a drastic increase in ED utilization of services and hospitals are having difficulties in strategies that could decrease the ED utilization.	Retrospective longitudinal cohort study	Data was obtained from two academic EDs in San Diego, California between September 2016 and August 2018 using data from a shared electronic medical record. One hospital is an urban academic teaching hospital (Level I trauma center) with an annual census of approximately 40,000 visits. The second hospital is a suburban community hospital, with an annual census of approximately 24,000 visits.	A total 45,959 ED patients were studied. 40,785 (88.7%) were nonfrequent users, (fewer than four visits in the 12- month period) and made up 55,710 (61.1%) of all the encounters. Females, ages 34-54, were frequent users of the ED services for pain symptoms. In 2015, 18% out of 136.9 million visits were made by uninsured patients.	Further research is needed to understand why current strategies are not influencing and decreasing the ED utilization rates by nonfrequent and uninsured users.	Improving ED utilization rates will permit for a reduction in non-emergency users and an enhancement in the quality of delivered healthcare services.	Yes
Cairns, C., Ashman, J. J., & King, J. M. (2023)	N/A	Does the uninsured continue to use the ED for healthcare services?	N/A	Data was obtained from the National Ambulatory Medical Care Survey and in 2021, 140 million ED visits occurred.	The national average is 33 per 100 visits for uninsured people and 36 for Hispanic people.	Further search is to be conducted that will explain the relationship between healthcare utilization in the ED and racial/ethnic group.	It has been established that uninsured Hispanics continue to use the ED for healthcare services and it's up to healthcare administrators to implemented and adopt change strategies in the delivery of healthcare services in ED's.	No

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Centers for Medicaid and Medicaid Services. (2021)	N/A	Does quality improvement s and measures enhance patient outcomes?	N/A	N/A	CMS uses quality improvements and measures to enhance healthcare outcomes for patients by identifying gaps within the population and the healthcare system and by implementing outcome-based measures.	Further research is needed to understand how ED's are implementing quality improvement measures to identify the needs of the population.	Improving quality improvement measures in the ED will enhance patient outcomes.	No
Choi, N. G., DiNitto, D. M., & Choi, B. Y. (2020)	Conceptualization theory	Medicaid insurance coverage does reduce the coverage gap for adults, ages 50-64.	Cross-sectional household survey	Data was obtained from National Health Interview Survey (years 2013- 2018) which holds a cross-sectional household survey including information on health coverage, healthcare access and health status characteristics for adults.	Per the authors, it has been reported that the uninsured obtained medical care from the emergency room department more often than those individuals with private insurance and used it less than Medicaid as well as were more likely to be admitted to the emergency room for conditions, have medical complications, longer hospital stays, higher medical charges, and self-pay.	Healthcare policy makers should analyze the current and expand the research into the effects of not having healthcare insurance on healthcare access resulting in the overuse of emergency room services.	Expanding Medicaid coverage in non-expansion states, will help adults (ages, 50-64), to qualify for this government program resulting in the access to healthcare services and decrease in emergency room visits and hospital stays.	Yes

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Dhollande, S., Taylor, A., Meyer, S., & Scott, M. (2021)	N/A	Integrative findings, within the healthcare system, does provide a framework and a holistic understandin g of the topic that will be researched.	N/A	N/A	According to the authors, an integrative review is a rigorous process in which all existing knowledge including, qualitative and quantitative research, gets analyzed allowing for a complete evaluation of the quality of the evidence, identifies gaps within the research, develops research questions, and most importantly, describes the theorical framework.	As time goes by, integrative reviews will continue to allow for a deeper understanding in a specific topic allowing for quality of the data to be analyzed and to evaluate current healthcare processes across departments. Such use of integrative reviews may influence healthcare administrators to apply the evidence to the healthcare facilities resulting in quality improvement.	The utilization of integrative reviews will permit for healthcare policy makers to completely audit the use of the emergency room for non- emergency conditions resulting in the holistic approach when implementing changes across the healthcare system.	No
Donabedian , A. (1988)	Donabedian SPO model	The SPO Model is utilized to examine quality since it explains how healthcare facilities are to be organized, have the need for sampling the population resulting in the desired state of the facility.	Donabedian SPO model S = Structure P = Process O = Outcome	N/A	Per the author, the Donabedian SPO Model, is a conceptual framework used to examine quality in the healthcare facility by evaluating how the structure and process is aligned with each other resulting in the desired outcome.	The Donabedian SPO Model should be utilized by healthcare administrators to audit the healthcare facility including the access and delivery of services with its influence on quality of health.	At a healthcare practice, healthcare administrators should be accustomed to use of the Donabedian SPO Model to improve processes in the delivery of healthcare services within the emergency room and primary care services resulting in positive outcomes for uninsured patients.	Yes

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Garfield, R., Orgera, K., & Damico, A. (2019)	N/A	Uninsured people, within the Medicaid gap, are far more likely than those with insurance coverage to postpone healthcare services.	N/A	N/A	Under the lack of Medicaid expansion in multiple states, 45% of the remaining uninsured individuals are not able to apply to ACA because either they reside in a state that did not expanded Medicaid, or their income makes them ineligible for any financial insurance assistance. Such insurance gap directly affects low-income families, which are 2.5 million people, because they are less likely to use primary care services, are likely to be hospitalized for preventable medical conditions and medical bills can lead to financial instability.	As time progresses, healthcare policy makers and state officials should revise Medicaid insurance eligibility requirements making it easier for uninsured Hispanics to qualify for this program and decrease the coverage gap within racial and ethnic groups.	For uninsured Hispanics, healthcare outcomes will be improved if non-expansion states can expand Medicaid eligibility requirements allowing for a reduction in uninsured patients.	No

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Han, J., Zhang, Y., No, G., & Urmie, J. (2020)	Self-efficacy model	Within the Medicaid gap, uninsured patients with chronic conditions do not have medication adherence and experience difficulties in affording medications	Retrospective cohort study	Data was obtained from Panels 19 and 20 (2014-2016) of the Medical Expenditure Panel Survey which include medical files, health conditions, prescription drugs, and demographic for 316 adults with chronic medical conditions.	Per the authors, most of the participants were females (60.4%) living in poverty and out of the total number of participants, only 48% had medication adherence. Hypertension was the prevalent medical condition followed by depression and anxiety. Also, the patients that did not have medication adherence suffered from hyperlipidemia. Patients had three or more medical conditions, took seven prescription drugs, and visited office- based providers six times.	This study has opened the door for future research to be conducted that will focus on how poverty levels have a direct impact on chronic conditions and medication adherence because of lack of affordability and insurance coverage.	Expanding Medicaid eligibility will help uninsured people who live below the poverty line to obtain medications and improve their overall quality of life and wellbeing; at this moment, it's up to the policy makers to expand Medicaid in non-expansion states making it easier for uninsured individuals to obtain insurance coverage and adhere to medications.	Yes
Jiang, L. G., Zhang, Y., Greca, E., Bodnar, D., Gogia, K., Wang, Y., Peretz, P., & Steel, P. A. D. (2022)	Andersen behavioral model	Efforts to facilitate healthcare access outside of ED can help in the decrease of avoidable non- emergency visits	Retrospective analysis	Data was collected from both the electronic health record, (EHR) as well as data internally collected by the Patient Navigator program and recorded, in the Patient Navigator Assessment from years 2016 to 2019.	Per the authors, four outcomes included 72-h return ED visits, 30-day return ED visits, overall, ED utilization, as well as the intervention group's adherence rates to PN-scheduled outpatient appointments. PN intervention was successful in decreasing post ED visits and outpatient adherence rates of 74-80%.	Further research is to be conducted that will link PN interventions with uninsured Hispanics to further understand the reasons of non-emergency visits in the ED.	Healthcare administrators should implement outpatient follow-up care post ED visit to help in the reduction of non-emergency visits.	Yes

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Kaiser Family Foundation. (2023)	N/A	Changes in the Affordable Care Act has permitted for state officials to decide if Medicaid will be or not be expanded.	N/A	N/A	States such as Arkansas, Idaho, Kentucky, and Maine have expanded Medicaid. North Carolina has adopted but has not expanded Medicaid as of 2023. State such as Florida and Georgia, have not expanded Medicaid.	As time progresses, it's imperative for policy makers to audit and further analyze the advantages there will be if non-expansion states do expand Medicaid eligibility requirements allowing for uninsured to obtain insurance coverage.	Medicaid expansion it's a subject that community leaders and healthcare administrators will need to continue to push for policy makers and state officials to expand Medicaid in non-expansion states.	No
Kraus, C. K., Moskop, J. C., Marshall, K. D., & Bookman, K. (2020)	N/A	Emergency Medical Treatment and Labor Act (EMTALA) mandates hospitals to provide emergency care for all incoming patients resulting in the increased demand for primary care healthcare services in the emergency room.	N/A	N/A	According to the authors, EMTALA was implemented to prevent uninsured patients for being transferred to another medical facility without clinical care and such mandate has allowed for primary care services to be provided in the emergency room departments.	Additional research should be conducted that will further the impact how EMTALA has had in the overuse of the emergency room department for non-emergency services such as routine services and medication refills as well as emergency and primary care services.	Patient health outcomes will be enhanced if healthcare administrators do find the root cause of why uninsured patients overuse the emergency room for primary care and non- emergency services; being able to identify this root cause will also permit for changes in the delivery and access of care to be implemented resulting in the increase of quality of care for patients.	No

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Lee, H., Hodgkin, D., Johnson, M. P., & Porell, F. W. (2021)	NAM disparity model	Adults, ages 19 – 64, living below the poverty line, do benefit from states to expand Medicaid allowing for there to be a decrease in insurance rates.	Quasi-experimental study	Data was obtained from National cross-sectional in- person survey and was restricted to U.S. citizens only (ages 19 to 64). Participants with incomes below 138% of the federal poverty line (FPL), for the years 2010 to 2016, and who were affected by Medicaid expansion were selected.	The authors have reported how in the states that Medicaid has been expanded, people were predominantly White (57% vs. 54%) and Hispanics (17% vs. 15%) and less likely to be Black (19% vs. 28%) while comparing non-expansion states. Between low- income and non- elderly adults, Medicaid expansion did decrease uninsured rates and Hispanics did have an increase in access measures such as unmet care while Whites had higher impacts on healthcare utilization.	At a state level, Medicaid expansion continues to change making it easier for healthcare researchers to continue to obtain data that will persuade healthcare officials to expand Medicaid leading for an increase in access to care and a decrease in uninsured rates.	Medicaid expansion has allowed for a reduction in health disparities for adult Hispanics, and therefore, this study can be utilized to analyze the positive impact Medicaid expansion has on uninsured rates across all racial/ethnic groups.	Yes
Levitt, L. (2021)	N/A	Was the Affordable Care Act was implemented to expand Medicaid eligibility and to include citizens who live below the poverty line?	N/A	N/A	Per the author, in 2012 the Supreme Court ruled that states would not be required to expand Medicaid to anyone with an income or 138% of the poverty level which translate to $17,800 for a single person and $30,000 for a family of 3 members. Hispanic and Black people have a higher uninsured rate, and the main reason is that 59% of the individuals in the Medicaid gap are ethnic minority groups.	Per this study, states that expanded Medicaid allowing for Hispanics to be insured, do cover 90% of the costs when delivering healthcare services. Further research is to be conducted on states that didn't expand Medicaid and evaluate if the reason for the lack of expansion is the costs associated with the use of healthcare services after obtaining insurance coverage.	Healthcare facilities will benefit from Medicaid expansion and healthcare administrators should closely monitor if cost is the reason why non- expansion states have decided to not implement Medicaid for all population.	No

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Lin, Y., Monnette, A., & Shi, L. (2021)	Andersen behavioral model for access to health care from Anderson healthcare utilization model	Insurance coverage it's a determinant for disparities when it comes to access to care and quality of life.	Cross-sectional national population survey	Data was obtained from Institutional Review Board at Tulane University. Years 2012- 2018, 7-year American Community Survey was utilized to obtain samples for subpopulations as well as demographics and socio- economic characteristics.	According to the authors, from years 2012-2018, Medicaid expansion states had a high federal poverty level while compared to non-expansion states making it easier for people to qualify and be enrolled in this government insurance coverage. The authors also reported how Medicaid expansion decreases health inequity and increases access to healthcare services.	Additional research must be conducted that will allow to further explain the correlation between the use of healthcare services and its impact on health inequity and quality of health for uninsured individuals in non-expansion Medicaid states.	Healthcare officials for non-expansion Medicaid states can utilize the results presented in this study to develop an expansion plan that will target families who live below the poverty line and experience health disparities with the solely purpose of enhancing their access to healthcare services.	Yes

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Parast, L., Mathews, M., Martino, S., Lehrman, W. G., Stark, D., & Elliott, M. N. (2021)	Complex theory	Hispanics continue to utilize the ED for routine services and ongoing medical conditions. Not emergency services.	Multivariate linear regression models	Data was obtained from Hospital-based ED's with 14,000 or more annual ED visits. A total of 3,122 survey's respondents were discharged from the selected 50 hospitals across the country from January-March 2016.	Per the authors, Hispanics reported visited the ED for ongoing medical conditions (30%) and more than three times within the last six months. Hispanics also reported to not having a usual source of medical care, do obtain services at the ED for less timely care and from poorer-quality facilities.	Further research is to be conducted that explains the reasons why Hispanics do not have access to a usual source of care such as primary care services and instead, they continue to utilize the ED for routine check-ups and medical treatment for ongoing medical conditions.	At a healthcare facility, this study can be used by a healthcare administrator to further expand the reasons why Hispanics continue to use the ED as a non-urgent source of medical care. Understanding why this continues to occur, will make it easier for healthcare administrators to change the processes when it comes to connecting patients with a primary care office after the treat-and- release visit resulting in the decrease in ED utilization for non-urgent conditions.	Yes
Perreira, K. M., Allen, C. D., & Oberlander, J. (2021)	Expanded health belief model and Anderson's socio-behavioral model	Children who have access to medical insurance are more likely to utilize preventative services, have a usual source of medical care and have less unmet medical needs.	Qualitative study	Data was obtained from Carolina Demography analysis of the U.S. Census 2019 American Community Survey (ACS) data.	Per the authors, post COVID 19 pandemic 90.8% of Hispanic children, (ages 0- 18) in states such as ME, MT, ND, and NH, are uninsured increasing the healthcare inequality gap.	Further research will need to be conducted that will expand the existing knowledge on the relationship between insurance coverage and health disparities for uninsured children.	Providing insurance coverage to uninsured children will enhance healthcare outcomes and decrease the inequality gap.	Yes

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Scott, K. W., Scott, J. W., Sabbatini, A. K., Chen, C., Liu, A., Dieleman, J. L., & Duber, H. C. (2021)	Cost model theory	How does a single-treat-and-release in the emergency room contributes to the cost increase for uninsured patients?	Cross-sectional study and linear regression model	The data was obtained from the National sample of hospital-based visits between 2006 and 2017 from Nationwide Emergency Department Sample.	Per the authors, 1 in 5 uninsured patients are in risk for a catastrophic health expenditure after obtaining healthcare treatment in the emergency room once released.	Additional research will need to be conducted that helps hospitals and healthcare administrators to understand the cost for emergency visits, treat-and-released, and how this visit does have an overall effect on the well-being of the uninsured.	Healthcare administrators can use the study to find the root cause of treat-and- release visits as well as expanding healthcare services into communities permitting for a reduction in the single use of emergency room for non- emergency visits.	Yes
Singer, A. J., Thode, H. C., & Pines, J. M. (2019)	N/A	Does uninsured patients utilize the emergency room for healthcare services?	Cross-sectional study	The data was obtained from a Retrospective Secondary analysis of discharged uninsured patients from the National Hospital Ambulatory Care Survey (NHAMCS) (2006-2016) and the Healthcare Cost and Utilization Project (HCUP) (2006-2016)	Per the authors, since the Affordable Care Act has expanded insurance coverage, there has been a slight decrease in the use of healthcare services by the uninsured as well as hospital discharges, from 14% to 8%.	Additional research is to be completed that will further study the changes in the delivery and access of the emergency room service after year 2016; such information will be able to understand the change in rates for healthcare utilization in the emergency room.	Healthcare administrators can utilize this study to understand the current utilization rates in the emergency room by uninsured, including discharge rates for treat-and- release visits, permitting for policy makers to make the necessary changes in the healthcare system that will help with maintaining costs in the emergency room.	Yes

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Ukert, B., & Giannouchos, T. V. (2023)	Andersen's behavior model	ACA was implemented to reduce ED utilization rate, but further studies do prove that uninsured Hispanic continue to use the ED for healthcare services.	Retrospective data analysis	Data was obtained from the Healthcare Cost and Utilization Project (HCUP) State Emergency Department Databases (SEDD) for Georgia, Florida, Massachusetts, and New York from 2011 to 2017. Participants were non-elderly adults between 18 to 64 years old and rated the visits as not preventable and injury-related, primary care treatable, preventable visits, and non-emergent visits.	According to the authors, the uninsured women, ages 18 to 34, with low- income, accounted for a large portion of the ED visits. Hispanic adults had the highest rate of uninsured ED visits for non-emergent, primary care treatable and preventable conditions.	Based on this study, healthcare policy makers, state officials and healthcare administrators, should focus on opening outpatient care facilities that will connect with the ED in post-release appointments allowing a regular access to healthcare services for uninsured Hispanics resulting in timely care and less patient flow in the emergency department.	As time goes by, it has become crucial for healthcare administrators to have a better and more efficient outpatient care program that will allow for uninsured Hispanics to access non- emergency and preventable services at a separate location and not in the emergency department.	Yes
Zambrana, R., Amaro, G., Butler, C., DuPont-Reyes, M., & Parra-Medina, D. (2021)	Sociodemography status theory	Race and education are associated with enhanced access to healthcare services and outcomes.	Cross-sectional study	An analysis of 101 data sets were obtained from Inter- University Consortium for Political and Social Research data archive with 1% Latino/a sample for year 2018.	According to the authors, to enhance health equity, additional data will have to be collected that will show the changes within the Hispanic population including migration history, socioeconomic status, health, and geography.	Further research will allow to understand how the changes in demographics and socioeconomic status does have a direct impact on insurance coverage and quality of health.	Improving data collection for health trends in the Hispanic population across the country, will provide opportunities to expand community-based interventions and policies for disadvantage populations who are uninsured.	Yes

Author/date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis and results	Conclusions	Implications for future research	Implications for practice	Empirical research
Zhan & Wu (2021)	Consumer theory for health insurance	Does uninsured people face barriers when accessing healthcare services leading for a decrease in use of primary care services and preventative care for chronic conditions?	Correlational study	Data was obtained from The Behavioral Risk Factor Surveillance Survey, years 2013-2020, 63,083 cases.	Per the authors, in the state of Texas, the uninsured does report more chronic health conditions while compared to Medicaid enrollees indicating the uninsured does experience health crisis because of lack of insurance coverage.	Expanding research in the effects of living in a non-expansion Medicaid state such as Texas, will further describe how the lack of insurance coverage does diminish the use of primary care services while at the same time, increases the use of healthcare services in the emergency room as well as the risk for chronic conditions.	At a state level, it's imperative for healthcare policy makers and state officials, to expand insurance coverage to uninsured Hispanics allowing for the overall improvement in the use of healthcare services in the emergency room and quality of life.	Yes

Appendix B: DHA Review Questions Search Log

Database or location name	Search terms	Results	Notes
CINAHL & MEDLINE Combined Search	emergency room or emergency department or er or ed OR value-based healthcare or vbhc or value-based care or value-based healthcare OR reimbursement or payment or insurance	53	Removed 4 articles for Medicaid/Medicare and 8 for third level of medical care resulting in 41 articles remaining for inclusion and exclusions screening.
ProQuest	HISPANIC OR Latin* AND Emergency room or emergency department or ER or ED or emergency services OR utilization rates AND no insurance	51	Removed 7 articles pertaining to vaccines resulting in 44 articles remaining for inclusion and exclusions screening.
Emerald Insight	Hispanic or Latin* OR no insurance AND value- based care	12	Removed 5 articles for studies outside of U.S.A. and/or medical studies resulting in 7 articles remaining for inclusion and exclusions screening
JAMA Network Open	Medicaid expansion and Affordable Care Act OR non-expansion Medicaid OR emergency room	13	Removed 3 articles for Covid-19 and/or opioid resulting in 10 articles remaining for inclusion and exclusions screening.
ScienceDirect	Hispanics OR Latino OR non-emergency OR emergency department or emergency room OR no insurance	312	
Backward/Forward hand searching reference list (Google Scholar)	N/A	4	

Appendix C: DHA Appraisal Results Log

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Agency for Healthcare Research and Quality. (2017). Characteristics of frequent users of three hospital emergency departments. AHRQ. https://www.ahrq.gov/patient-safety/settings/emergency- dept/frequent- use.html#discussion	Evidence level V and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Screening Checklist of emergency department patients The purpose of this study was to identify the factors that influence patient's frequent use of the emergency department for non-emergency conditions. Risk factors for high ED use include lack of insurance and primary care, psychiatric illness, substance abuse, cognitive/physical impairment, and inability to understand discharge instructions.	Between 4.5% - 8% are frequent users of the ED counting for 21%-28% of all ED visits. High-frequency emergency department utilization rate is four or more visits in the previous 12 months or three or more prior visits in the previous 3 months or one or more prior visit in the previous 72 hours. 6.7% of uninsured patients do use the ED for non-emergency services and 14.3% do not have a primary care provider.	Environmental scan of existing literature and medical records was conducted to explain the ED procedures including discharge processes. Total number of participants, 386 and three hospital ED's. A screening checklist was used to identify high ED users and with one more risk factor.	Study only focused on six risk factors that could influence the overutilization of ED services and did not include chronic health conditions. It was stated that 87% of the studied population had at least one chronic condition.
Alnasser, S., Alharbi, M., AAlibrahim, A., Alibrahim, A., Kentab, O.	Evidence level III and quality rating High	HSO Type: Hospital Facility (emergency department)	Reasons of non- emergency ED use include routine examinations and/or primary care services,	Retrospective review of electronic medical records of non- and less-urgent ED visits in a hospital within a	Study was conducted during at a hospital within a university and might not have participants that could represent the demographics

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Alassaf, W., & Aljahany, M. (2023). Analysis of emergency department use by non-urgent patients and their visit characteristics at an academic center. International Journal of General Medicine, Volume 16, 221–232. https://doi.org/10.2 147/ijgm.s391126		Research Domain: Chart review of 18,880 patients in ED with Canadian Triage and Acuity Scale of 4 or 5 and 11,857 patients with missing CTAS levels. The purpose of this study was to identify the reasons why patients utilize the ED for non- and less-urgent conditions resulting in negatively affecting the quality of care of the patients while at the same time, prolonging medical care and increased risk of adverse outcomes.	medication refills, laboratory tests, to obtain a sick leave form, headaches and migraines, ear, nose, and throat infection, wound care, fatigue, and upper respiratory symptoms. Patients who visited the emergency department for non-emergency conditions are 61.4% and such visits resulted in a single diagnosis not hospitalization.	university. Patients were categorized from 1 to 5, 1=resuscitation, 2=emergency visit that requires triage within 1-14 minutes and immediate care, 3=urgent visit that received medical treatment within 60 minutes, 4=less- urgent and can be evaluated between 1-2 hours, and 5=non-urgent visits with 24 hour delay.	of the population in which this university is located.
Al Rifai, M., Mahtta, D., Kherallah, R., Kianoush, S., Liu, J., Rodriguez, F., Nasir, K., Valero, J., Khan, S. U., Ballantyne, C., Petersen, L. A., & Virani, S. S. (2021). Prevalence and determinants of difficulty in accessing medical care in U.S. adults. American Journal of Preventive Medicine, 61(4), 492–500. https://doi.org/10.1016/j.amepre.2021. 03.026	Evidence level III and quality rating Good	HSO Type: Doctor's office (primary care services) Research Domain: Telephone-based questionnaire survey of adults aged 18 years and older. The purpose of this study was to determine patient's difficulties in accessing preventative services for high-risk chronic conditions including hypertension, diabetes, and heart conditions.	A total of 14% of adults in this study reported difficulties in accessing medical care. Prevalence of hypertension was 33%, diabetes was 11%, and heart conditions was 9%. Participants who reported difficulties in accessing medical care were young, female (51%), Hispanic (17%), low income, unemployed, lived in a state without Medicaid expansion, uninsured, and less than high school education, and did not have a primary care provider.	Behavioral Risk Factor Surveillance System (BRFSS) survey is a nationwide telephone-based questionnaire survey used to evaluate chronic health conditions, health- related risk behaviors, and the use of preventive services and is administered to a random representative sample of U.S. adults aged 18 years and older. The survey was analyzed by multivariable-adjusted logistic regression models to correlate sociodemographic with access to medical care.	A limitation of this study was that the population sample obtained in the Telephone-based questionnaire survey may not capture all the reasons for experiencing difficulties in accessing medical care broken down by state especially in non-expansion Medicaid states and states with high percentage of Hispanic population.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Ayanian, J. Z., & Markel, H. (2016). Donabedian's lasting framework for Health Care Quality. New England Journal of Medicine, 375(3), 205–207. https://doi.org/10.1 056/nejmp1605101	Evidence level V and quality rating Good	HSO Type: Non-HSO environment; Healthcare system; Quality Improvement Research Domain: Integrative review on Donabedian's SPO model. The purpose of this article was to discuss existing challenges that remain with quality measurement of healthcare facilities.	No review question was included, but Donabedian's SPO model explained the importance of healthcare facilities having measurement standards when analyzing samples of the population and measuring quality of care. Such care measurements should include prevention, rehabilitation, coordination, and continuation of care. Current day value-based payments and patient-centered outcomes can be analyzed and traced back to Donabedian's SPO model.	Integrative review of Donabedian's conceptual framework on quality of care.	Source limitations not included since this study is an integrative review of Donabedian's SPO model and measurement on quality of care for healthcare facilities.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Ayón, C., Ramos Santiago, J., & López Torres, A. S. (2020). Latinx undocumented older adults, health needs and access to healthcare. Journal of Immigrant and Minority Health, 22(5), 996–1009. https://doi.org/10.1 007/s10903-019-00966-7	Evidence level III and quality rating High	HSO Type: Non-HSO environment; Healthcare system Research Domain: Undocumented older Hispanic population and difficulties in accessing healthcare services. The purpose of this study was to determine the relationship between being undocumented older Hispanic, experiences, and access to healthcare services.	70% of undocumented people are of Latino/a origin and approximately, 60% are uninsured. Participants reported that delay in medical care is due to the following: First, fear of being deported by disclosing residence address when seeking medical care, second, healthcare debt, due to low wages, if a participant were to miss work to attend a medical visits, this is earning loss and can contribute to financial hardship, third, language, 50% of older undocumented were limited English proficient, this language barrier makes it difficult for the patient to explain the health issues and to comprehend medical information.	Qualitative study. Thirty participants were ages 55 years old and up and were selected from a community advisory board in California. 60% men and 40% females. Participants were from Mexico, Argentina, and Guatemala. Incomes below $20,000. Interview questions included immigration effects on their lives, access to healthcare and socioeconomic resources and support structures.	This study does not state how paying for out-of-pocket healthcare services at a community center does help in the overall well- being of the individual, instead, it states how members have access to obtain healthcare services at community centers and public hospitals.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Backhouse, A., & Ogunlayi, F. (2020). Quality Improvement Into Practice. BMJ, 638, 1–6. https://doi.org/10.1 136/bmj.m865	Evidence level V and quality rating Good	HSO Type: Non-HSO environment; Healthcare system; Quality Improvement Research Domain: Expert opinion on quality improvement for the healthcare system. The purpose of this article was to explain how healthcare professionals do not follow quality improvement principles or alternatives that will allow change in processes resulting in the enhancement of the healthcare system.	No review question was included but the principles of quality improvement include primary intent – specific aspect of healthcare that's to be improved, employing and testing – selecting a theory of change resulting in hypothesis and results, methodology – tools to measure quality, empowerment – engage of healthcare professionals with useful skills to improve quality, data – analyze existing data to further evaluate processes and outcomes, adapt – implement quality improvements and spread to new environments.	Expert opinion on how healthcare facilities can use quality improvement to enhance processes resulting in improved patient outcomes and professional roles in the healthcare setting.	Source limitations not included since this study is an expert opinion on how to use quality improvement principle and alternatives to narrow the gap between the healthcare system and professionals.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Biese, K., Lash, T. A., & Kennedy, M. (2022). Emergency department care transition programs—value- based care interventions that need system-level support. JAMA Network Open, 5(5), 1–3. https://doi.org/10.1 001/jamanetworkopen.2022.13160	Evidence level V and quality rating Good	HSO Type: Hospital Facility (emergency department) Research Domain: Quality improvement callback program in the emergency department and its incorporation with value- based care programs. The purpose of this article was to evaluate the unnecessary and unplanned emergency department visits by patients who did not enroll in the callback program did return within 72 hours.	Patients who answered the automated call, visited their healthcare professional, had a vast understanding of discharge instructions, were less likely to return to the ED within 72 hours and lower rate of hospital admission at 7 days while compared to patients who were not reached by this program. This callback program is to be aligned with value- based care programs guaranteeing quality of care and unnecessary ED visits.	This study lasted 10 weeks, 8,110 total number of participants and 2,958 (36.5%) enrolled in the callback program. One-fourth of the patients selected a language other than English, and one- third answered the automated call, explained understanding of discharge instructions.	In this callback program, one-fourth of the participants selected a language other than English, but this study did not specify which ethnic or racial groups participated as well as other demographic information such as age and gender.

Bornais, J. A. K., Crawley, J., & El- Masri, M. M. (2020). One stop: Examining the reasons patients use the emergency department for Nonurgent Care and the barriers they face. Journal of Emergency Nursing, 46(2), 163–170. https://doi.org/10.1016/j.jen.2019.08.007	Evidence level III and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Qualitative description of patient's perspective when accessing the ED for non- urgent conditions. The purpose of this study was to describe the reasons behind utilizing the ED for non-urgent conditions and barriers when accessing a primary care provider.	Three main reasons why patients visited the ED for non-urgent condition: First, 12 participants called their primary care provider and were referred to the ED for medical care. Second, 16 participants mentioned how the ED provides efficient medical care while compared to a primary care facility. Third, 26 participants stated they had to wait days for a primary care visit while in the ED the wait time might be 2-3 hours but is faster and saves time. Three barriers when accessing healthcare services outside of the ED. First, 7 participants did not have a primary care provider which further describes why these patients continue to access the ED for non-urgent conditions. Second, 11 participants are uninsured, cannot afford healthcare services such as primary care, and must obtain care at the ED. Third, 20 participants explained how one problem per visit rule makes it difficult with primary care, 26 participants mentioned how they feel rushed during office visits, and 23 participants use the ED to obtain all services (e.g. lab and specialists) in one visit instead of multiple visits with primary care.	Qualitative descriptive design, face-to-face English interview, a total of 33 participants (12 men, 21 women, ages 19-72), 4 ED's, and non-urgent conditions. Participants answered questions related to the reasons on why accessing the ED for a non- urgent condition, overall, ED experience and barriers when accessing a primary care outside of the ED. Data was collected during ED peak times and when primary care offices were opened.	A limitation of this study was that the questions were open-ended, therefore, the participants perception may only be about the visit and not included an overall perspective on accessing the ED for non-urgent services as well as barriers when accessing healthcare services outside of the ED.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Cairns, C., Ashman, J. J., & King, J. M. (2023). Emergency Department Visit Rates by Selected Characteristics: United States, 2021. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/databrief/db478.pdf	Evidence level III and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: ED visits per ethnic group and gender. The purpose of this National Hospital Ambulatory Medical Survey was to provide statistics on ED use for uninsured Hispanics.	No review question was included, but the national average for hospital utilization rates in the emergency department utilization is 33 per 100 visits, for uninsured patients and 36 per 100 visits for Hispanics.	National survey and average on ED use for uninsured and Hispanics.	Source limitations not included since this study is a national survey by the CDC on ED visits.
Centers for Medicaid and Medicaid Services. (2021). Quality measurement and quality improvement. CMS. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement-#:~:text=CMS%20uses%20quality%20improvement%20and,burden%20on%20clinicians%20and%20providers	Evidence level V and quality rating Good	HSO Type: Non-HSO environment Research Domain: Evaluation on how quality improvement works with quality measurement to enhance patient outcomes. The purpose of this article was to explain how quality improvement is the framework to be utilized when improving care.	No review question was included but described how quality improvements and measures to enhance healthcare outcomes for patients by identifying gaps within the population and the healthcare system and by implementing outcome-based measures. Quality improvement is also standardization indicating that good decisions lead to good results, therefore, patients use quality measures to select a high-performing healthcare provider and providers to evaluate their own performance.	Evaluation on how quality improvement and measurement work together to achieve goals that will result in a decrease in provider burden and an increase in patient outcomes.	Source limitations not included since this study is an evaluation on how healthcare facilities can use quality improvement and measurement to yield positive results and use of best practices in care.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Choi, N. G., DiNitto, D. M., & Choi, B. Y. (2020). Unmet healthcare needs and healthcare access gaps among uninsured US adults aged 50-64. International Journal of Environmental Research and Public Health, 17(8), 2711, 1-12. https://doi.org/10.3 390/ijerph1708271 1	Evidence level III and quality rating High	HSO Type: Health Insurance Company Research Domain: Healthcare needs and access gaps for uninsured adults, ages 50-64. The purpose of this study was to evaluate relationship between being uninsured and the overall health of adults, ages 50-64. This age group is at a higher risk of chronic health conditions when experiencing unmet healthcare needs due to being uninsured.	Adults, ages 18-64, have reported having two or more chronic health conditions, experience difficulties in accessing healthcare services due an uninsured period, and visited the ED for medical care. 9.9% of age group, 50-64, were uninsured, reported not having a usual source of accessing healthcare services, 12.4% had financial difficulties in paying for medical costs which resulted in delayed care, and 47.2% express concerns about affording medical bills. Almost 25% of the participants were uninsured Hispanics and two-thirds reported working in the past year, but 43.3% live below the poverty line. 60% of uninsured near-older adults had a contact with a safety-net healthcare system which does not help in closing the access gap since there's the financial burden of paying medical bills.	Cross-sectional household survey, years 2013–2018, 49,293 participants, and from National Health Interview Survey (NHIS). Data included insurance coverage, face-to- face interviews with an adult member, questions pertaining to healthcare access and health status. Six categories in this survey included: uninsured, private insurance, VA/military, Medicare without Medicaid, dual Medicaid and Medicare, and Medicaid without Medicare.	The uninsured rate reported in the survey, did not included specific data since participants only had the option to select having insurance any time during the past year which does not explain if any of the participants had coverage for a portion of the year or the entire year. No description was provided on the challenges uninsured Hispanics experience when living below the poverty line and health implications.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Cobb, S., Bazargan, M., Assari, S., Barkley, L., & Bazargan-Hejazi, S. (2022). Emergency department utilization, hospital admissions, and office-based physician visits among under- resourced African American and Latino older adults. Journal of Racial and Ethnic Health Disparities, 10(1), 205–218. https://doi.org/10.1 007/s40615-021-01211-4	Evidence level III and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: To identify the relationship between being an older foreign-born Latino, predisposing characteristics, and ED utilization. The purpose of this study was to understand how older and foreign-born Latinos utilize the emergency department frequently.	Foreign-born older Latino, have undiagnosed and uncontrolled medical chronic conditions and lack access to medical care. 19.6% of Latinos reported at least six chronic conditions, live in medically underserved areas in U.S., have low access to primary care services and, frequent use of ED services for circulatory and respiratory conditions. Older adults who have less access to office-based visits influence the utilization of ED for medical services.	A total 905 participants were recruited from senior housing areas, senior community centers and faith-based organizations located in 52 community sites in South LA. Surveys were provided in English and Spanish and face-to-face interviews conducted. Participants answered questions related to quality of health, smoking status, ED utilization, financial strains, office-based primary care access, and socioeconomic status.	Two limitations in this study: First, the authors only had access to participants perception on healthcare access, including ED and office-based primary care, and chronic conditions, but not to medical records, therefore, the information was only a self-report and overall experience. Second, the study sample was non-random and only from South LA.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Cronin, A. O., Morton, D. J., Brennan, J. J., & Castillo, E. M. (2020). Frequent emergency department visitors associated with a pain-discharge diagnosis. The Journal of Emergency Medicine, 59(3), 357–363. https://doi.org/10.1 016/j.jemermed.202 0.06.058	Evidence level I and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Definition and reasons of frequent ED utilization. The purpose of this study was to identity what is frequent ED utilization and the reasons why patients continuously access medical care at the ED.	Frequent ED utilization is six or more visits to a rural hospital in a 12-month period, four or more visits to an urban ED four or more times per year, and at least four visits to an ED in a 12-month period. 40,785 (88.7%) were nonfrequent ED users. 5,174 (11.3%) were frequent users and accounted for 40% of ED visits. The frequent users with pain-related visits were 34-54 years old. Frequent ED patients are in need for coordinated medical care, have recurrent health conditions, and cannot obtain the necessary medical care that will improve health outcomes in the long- term.	A retrospective longitudinal cohort study of two hospitals in San Diego, California. Years, 2016-1028. One urban academic hospital (Level I trauma) and a suburban community hospital. Participants (45,959) were classified into different pain groups: non-pain users (0 pain visits), occasional pain users (1–3 pain visits), and frequent pain users (4 or more pain visits).	This study obtained data from two hospitals and within the state, therefore, the participation sample may not represent other communities across the country since it was not specified which ethnic groups were frequent ED users with pain related diagnosis.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
de Silva Etges, A. P., Liu, H. H., Jones, P., & Polanczyk, C. A. (2023). Value-based reimbursement as a mechanism to achieve social and financial impact in the healthcare system. Journal of Health Economics and Outcomes Research, 10(2), 100–103. https://doi.org/10.3 6469/001c.89151	Evidence level V and quality rating High	HSO Type: Non-HSO environment; Hospital Systems Research Domain: Literature review of value- based reimbursement and fee-for service payment models in the healthcare system. The purpose of this study was to evaluate the differences between value- based reimbursement and fee-for service payment models.	No review question was included but described the difference between both healthcare payment models. Fee-for service payment model reimburses providers directly for the delivered care without taking into consideration the patient's overall health. Value-based reimbursement aligns the interest of patients, providers, and payer. Financial incentives are given to providers who deliver enhanced patient outcomes without increasing healthcare costs. Two approaches of Value-based reimbursement: Capitation payment which is a fixed amount of money to providers who deliver complete and coordinated benefits to patients over a period of time. Providers do face the risk of losing money and are incentivized to reduce medical care. Bundled payment, providers are paid up front for the complete medical care of a patient. This prioritizes the quality of delivered healthcare services while reducing costs.	Literature review on how the healthcare system financially incentivizes healthcare providers to delivery medical care while at the same time reducing costs and increasing quality of health and care for patients.	Source limitations not included since this article is a literature review provided the differences between two payment models in the healthcare system, value-based reimbursement, and fee-for service.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Dhollande, S., Taylor, A., Meyer, S., & Scott, M. (2021). Conducting integrative reviews: A guide for novice nursing researchers. Journal of Research in Nursing, 26(5), 427–438. https://doi.org/10.1 177/1744987121997907	Evidence level V and quality rating High	HSO Type: Non-HSO environment; Healthcare System Research Domain: Integrative reviews allow a holistic perspective on the functions and processes of the healthcare system. The purpose of this position statement was to in-dept explain all the steps when conducting an integrative review.	No review question was included but an integrative review is a rigorous process in which all existing knowledge including, qualitative and quantitative research, gets analyzed allowing for a complete evaluation of the quality of the evidence, identifies gaps within the research, develops research questions, and most importantly, describes the theoretical framework.	Integrative review is utilized by healthcare professionals to analyze the accessible evidence and apply it to the clinical practice as well as healthcare policy makers to make informed decisions permitting for there to be patient oriented and reliable results	Source limitations not included since this article explains the process and the importance of integrative review within the healthcare system.
Donabedian, A. (1988). The quality of care. how can it be assessed? JAMA: The Journal of the American Medical Association, 260(12), 1743–1748. https://doi.org/10.1 001/jama.260.12.1743	Evidence level V and quality rating High	HSO Type: Non-HSO environment; Healthcare system; Quality Improvement Research Domain: Conceptual framework for quality improvement in the healthcare system The purpose of this article was to explain Donabedian's structure, process, and outcome model (SPO model)	No review question was included but the structure is the healthcare facility, process is how the facility delivers medical care and outcome is patient's survival. The SOP model is useful when assessing quality because it establishes how healthcare facilities need to be organized, have adequate sampling of the population, and have structure resulting in good healthcare processes for patients.	With the use of Donabedian's structure, process, and outcome model (SPO model), healthcare facilities can measure quality and work towards improvement of the structure and processes resulting in positive patient outcomes.	Source limitations not included but this article reviews the Donabedian's structure, process, and outcome model (SPO model) and it's use for quality improvement in healthcare facilities.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Drake, P., Tolbert, J., Rudowitz, R., & Damico, A. (2024). How many uninsured are in the coverage gap and how many could be eligible if all states adopted the Medicaid expansion?. Kaiser Family Foundation. https://www.kff.org/medicaid/issue- brief/how-many-uninsured-are-in- the-coverage-gap- and-how-many-could-be-eligible- if-all-states-adopted-the- medicaid-expansion/	Evidence level V and quality rating High	HSO Type: Non-HSO environment Research Domain: Relationship between non- expansion Medicaid states, uninsured states and being Hispanic. The purpose of this article was to identify the states that have not adopted Medicaid expansion and those remaining uninsured who fall under the Medicaid gap.	No review question was included but 40 states have expanded Medicaid while 10 states have not expanded leaving 1.5 million uninsured people without insurance options. States that have not adopted Medicaid expansion, Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, Wyoming. Top three states with the highest concentration of uninsured adults: Texas (one in four), Florida (19%) and Georgia (12%). 97% of adults in the Medicaid gap live in the South Hispanics are 21%-25%. Uninsured adults who fall under the Medicaid gap have incomes above the state's Medicaid eligibility and subsidies in the Marketplace are not available for adults who live below the poverty line of $20,782 yearly.	A program evaluation of Medicaid insurance including expansion states (40) and non-expansion states (10). Most Medicaid gap adults reside in the South of the country, Texas, Florida, and Georgia with 21%-25% of the recipients are Hispanics.	Source limitations not included since this was a program evaluation of Medicaid non-expansion states, Hispanics, and uninsured status.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Escobedo, L. E., Cervantes, L., & Havranek, E. (2023). Barriers in healthcare for Latinx patients with limited English proficiency—A narrative review. Journal of General Internal Medicine, 38(5), 1264–1271. https://doi.org/10.1 007/s11606-022-07995-3	Evidence level III and quality rating High	HSO Type: Hospital Facility; Doctor's Office Research Domain: Health disparities for Latinos and limited English proficiency with its impact on healthcare access and utilization of services. The purpose of this study was to explain how language influences access and perception of medical care.	Limited English proficiency is the biggest challenge faced by the Hispanic/Latinos population (25% reported difficulties when scheduling appointments and 29% of Spanish speaking patients did not have medical resolutions after an appointment). This is the biggest predictor of confusion, poor care and frustration when accessing healthcare services due to lack of interpreters, time during visits and Spanish speaking healthcare clinicians. Three themes related to inferior medical care: no Spanish language services, misidentifying the patient and feeling of discrimination.	PubMed studies from 1990 and March 2021, were studied that included Hispanics/Latinos language and healthcare information. Qualitative interviews. The following themes were recurrent in the 91 studies, limited English proficiency, immigration status, cultural traditions, and social needs and faith.	This study presented information on how Hispanic/Latinos who experience limited English proficiency have difficulties when accessing healthcare services, but it did not explain if such difficulties are experienced in the emergency department and how this affects the overall perception of the Spanish- speaking patient.
Garfield, R., Orgera, K., & Damico, A. (2019). The Uninsured and the ACA: A Primer. The Kaiser Family Foundation. Retrieved from https://files.kff.org/ attachment/The- Uninsured-and-the- ACA-A-Primer-Key-Facts-about- Health-Insurance- and-the-Uninsured- amidst-Changes-to- the-Affordable- Care-Act	Evidence level V and quality rating Good	HSO Type: Non-HSO environment Research Domain: Integrative review of the Medicaid gap and uninsured population in U.S. The purpose of this integrative review was to explain the gaps in the U.S. healthcare system and how it affects the population that remains uninsured even after the expansion of the Affordable Care Act.	No review question was included but uninsured people are far more likely than those with insurance to postpone health care; therefore, the consequences can be severe, since preventable and chronic conditions do go undetected. 45% of those who are in the Medicaid gap do not qualify for ACA because of the lack of Medicaid expansion, immigrant status, state of residence, work status, and income	Evaluation on insurance gap and lack of access to other insurances does have an influence on the uninsured population when it comes to accessing and affordability of healthcare services.	Source limitations not included since this was an integrative review of healthcare and insurance gaps for the uninsured population even after the expansion of the Affordable Care Act.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Han, J., Zhang, Y., No, G., & Urmie, J. (2020). Medication adherence among chronic condition patients in the Medicaid coverage gap. Research in Social and Administrative Pharmacy, 16(7), 982–986. https://doi.org/10.1016/j.sapharm.2019.11.011	Evidence level II and quality rating High	HSO Type: Drug Company; Healthcare system Research Domain: Uninsured adults living in poverty, suffering from multiple chronic conditions and its influence of medication adherence. The purpose of this study was to evaluate how uninsured adults who fall under the Medicaid gap, live below the poverty line and are unable to have medication adherence.	Most of the participants live in the south of U.S., live in poverty, 60.4% were women and 63.7% were non-Hispanic white. Almost 80% of the patients were underinsured (59%) or unceasingly uninsured (21.6%). Participants had three chronic conditions, were prescribed, and used seven medications, visited office-based healthcare services six times and only 48% of the total number of participants had medication adherence. Of all chronic conditions, hypertension was the predominant in the data sample followed by mental health conditions such as depression and anxiety. Patients with high cholesterol was most likely to not take the prescription.	Retrospective cohort Study. 316 participants, average age of 50 and three health conditions. Data was obtained from the Medical Expenditure Panel Survey, years 2014-2016 including information on prescribed medications, health conditions, chronic conditions, and demographics. Medication adherence was measured using Medication Possession Ratio. Underinsurance was classified into out- of-pocket expenses, delays, or failure to access healthcare services due to costs and inability to afford medical bills.	The limitation this study presented is the lack of information if the low rates of medication adherence are from a racial/ethnic group, such as Puerto Ricans and/or Mexicans and Central Americans as which southern states have high rates of nonmedication adherence.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Hannawa, A. F., Wu, A. W., Kolyada, A., Potemkina, A., & Donaldson, L. J. (2022). The aspects of healthcare quality that are important to health professionals and patients: A qualitative study. Patient Education and Counseling, 105(6), 1561–1570. https://doi.org/10.1 016/j.pec.2021.10.016	Evidence level III and quality rating High	HSO Type: Hospital Facility Research Domain: Processes of quality of care. The purpose of this study was to explore healthcare providers, nurses, and patients' perception of quality of care.	Six pillars of high- quality care: safety (prevents harm for patients), effectiveness (based on scientific knowledge), patient centeredness (respectful and responsive to patient's needs and values), timeliness (decreases wait times and additional delays), efficiency (avoids any type of waste), and equity (no discrimination). Good quality can be found between healthcare professionals who share a sense of pride about the care they have achieved with patients. Rapid reactivity enhances quality of care when healthcare providers respond quickly to errors while delivering care.	A qualitative survey design, summer of 2018. 53 respondents (16 doctors, 21 patients and 16 nurses), 97 narrative descriptions (53 of exceptionally good and 44 of unacceptably poor). Coders identified 551 codes pertaining to good/poor quality of care. Survey was completed both online and in paper format across eight hospitals. Each participant described the reason of the healthcare appointment, actions by the clinical staff and outcome.	Since this is a non-random sample of healthcare professionals and patients, qualitative study, does not allow for the results to be generalized to the entire population.
Hsuan, C. (2023). Improving hospital transfers: A step toward equitable, patient-centered acute care. Forefront Group, 1–9. https://doi.org/10.1377/forefront.20230 913.875025	Evidence level V and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Transfer of patients from emergency department to other healthcare facilities. The purpose of this article was to enhance coordinated medical care through quality-improvement programs.	No review question was included but EMTALA doesn't apply once a patient has been medically stabilized. Quality-improvement programs and healthcare providers payments are established according to the medical care patients have received since hospital arrival to discharge.	Integrative review of EMTALA, improving hospital transfers, patient-centered care, and provider payment policy.	Source limitations not included since this was an article explaining when EMTALA covers a patient and how quality-improvement initiatives help in patient transfer to other healthcare facilities.

Jiang, L. G., Zhang, Y., Greca, E., Bodnar, D., Gogia, K., Wang, Y., Peretz, P., & Steel, P. A. D. (2022). Emergency department patient navigator program demonstrates reduction in emergency department return visits and increase in follow-up appointment adherence. The American Journal of Emergency Medicine, 53, 173–179. https://doi.org/10.1 016/j.ajem.2022.01.009	Evidence level II and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Avoidable emergency department visits. The purpose of this study was to describe the overutilization of the emergency department due to poor access to timely outpatient care and use of patient navigator program (PN).	Steps of this program: Upon ED discharge, patient is referred to the program with a discharge plan (appointments and follow-up plan) Providers identify the medical needs and insurance barriers for the patient, Navigators interview the patients for appointment availability and schedule of appointments. Reminder call: 24-72 hours prior to appointment, patient receives a reminder call. Adherence call: 24-72 hours post appointment; navigator program confirms if the patient attended the appointment. Case complete (if patient attended the appointment) or rescheduling of appointment. 56% of ED visits are avoidable, frequent ED utilization is up to 28% of all ED visits and $38 billion annual goes towards ED spending. Average age was 21 to 44 years old, 56% were male, 65% were non- White, half was Hispanic/Latino, and 15% did not speak English. Pre-PN group, had a decrease in 72hrs return visit from 2% to 1% and 30-day return visits decreased from 7.9% to 3.9%. Post-PN group, had a decrease in 72hrs return visit from 1.6% to 1.0% and 30-day return visits	PN was created to understand healthcare access barriers, provide solutions, and gives the uninsured with peer-based education on how to navigate the system and use of resources. Data (demographic and insurance information) was collected from electronic health record for three consecutive years (years, 2016-2019) and patient navigator program from two urban hospital based ED's in New York City. Total number of collected records: 42,885, ages 21 to 105. Patients were not directly involved in this study. Data was analyzed by descriptive statistics and propensity score matching. Patients were divided into two groups, pre-PN and post-PN and labeled as having completed or remain in active status for this program. One case intervention group was matched against two control groups. The case group was patients who were new in PN and the two control groups were patients who completed PN.	A limitation of this study is the fact that due to the population size in NYC, patients may access medical services at other healthcare facilities as well as insufficient information on ED return visits.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
			decreased from 6.9% to 3.9%.		
Kraus, C. K., Moskop, J. C., Marshall, K. D., & Bookman, K. (2020). Ethical issues in access to and delivery of emergency department care in an era of changing reimbursement and novel payment models. Journal of the American College of Emergency Physicians Open, 1(3), 276–280. https://doi.org/10.1 002/emp2.12067	Evidence level V and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Healthcare access in ED's because of Emergency Medical Treatment and Labor Act (EMTALA) The purpose of this article was to explain the importance of EMTALA in delivery of medical services in the ED.	No review question was included but in 1986, Congress recognized how ED's were the primary safety net for the healthcare system which is known to be as EMTALA. This Act prohibits healthcare professionals to transfer uninsured patients to other healthcare settings without providing medical stability. In the ED's, patients have the right to receive medical screening examination, stabilization of the medical condition regardless of patients' affordability of healthcare services. EMTALA mandates for ED's to provide healthcare services for all patients. The following reasons explain why patients obtain primary services from the ED; first, patients are referred by the primary care provider to obtain urgent and critical medical care at the ED, second, patients without a usual source of medical care only have the option to obtain care at the ED, third, patients can obtain care after working hours.	EMTALA has expanded medical care accessibility for uninsured patients to obtain healthcare services in the ED including primary care services, since this Act prohibits for patients to be transferred to other healthcare facilities without receiving medical care.	Source limitations not included since this was a literature review explained the pros and cons and history behind the enactment of EMTALA.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Lago-Hernandez, C., Nguyen, N. H., Khera, R., Loomba, R., Asrani, S. K., & Singh, S. (2021). Cost-related nonadherence to medications among us adults with chronic liver diseases. Mayo Clinic Proceedings, 96(10), 2–18. https://doi.org/10.1 016/j.mayocp.2021. 02.026	Evidence level II and quality rating High	HSO Type: Hospital System Research Domain: Financial distress of medical bills and cost-related medication nonadherence. The purpose of this study was to describe the relationship between being a patient with major chronic conditions, healthcare access in ED's, financial distress, and cost- related medication nonadherence.	1 in 4 patients had liver disease, 17% experienced cost-related medication nonadherence, 12% skipped medication doses and 16% delayed refills to save money, and 13% took less medications. Patients reported accessing unplanned healthcare services in the ED because of illness-related and not being able to work. Out of the total number of participants, 57% were middle-aged (40 and 64 years old), 40% were low-income, 7% were uninsured, and 51% were obese. While comparing patients without medication nonadherence, patients with liver disease and experiencing medication nonadherence, were younger, more frequently women, uninsured, lack paid sick leave, and more like come from a low-income family.	Data was obtained from National Health Interview Survey, 2014-2018 and 152,836 participants. Cross-sectional national survey and questions pertaining to demographic, socioeconomic, health conditions from one random selected adult member from each household. Criteria for participant selection: diagnosis of chronic conditions, such as heart disease diabetes, obesity, and kidney disease. Also, financial hardship for not being able to afford medical bills or medication as well as unplanned ED visits.	Since this is a self-reported cross-sectional national survey, participants would report if they experienced liver disease or not; therefore, there was not adequate validation of this requirement to participate in the study. However, this reporting does expand the official estimates of disease liver in U.S.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Lee, H., Hodgkin, D., Johnson, M. P., & Porell, F. W. (2021). Medicaid expansion and racial and ethnic disparities in access to health care: Applying the National Academy of Medicine Definition of health care disparities. INQUIR Y: The Journal of Health Care Organization, Provision, and Financing, 58, 1-14. https://doi.org/10.1177/0046958021991293	Evidence level II and quality rating High	HSO Type: Health Insurance Company Research Domain: Medicaid expansion effect on the uninsured. The purpose of this study was to evaluate the effect of Medicaid across the states who adopted this insurance expansion.	Participants were younger, male, larger family size, higher education status, reside in rural area, less likely to be married, and have higher unemployment rates. Uninsured rates decline by 6.5%. Hispanics had a decrease (-7.4%) in rates of delayed care and unmet need for medical care due to cost. Hispanics had an insurance increase of 17%, but even after this insurance expansion, this study showed how there is not an usual source of care such as having a physician visit, which indicates there's not an improvement in healthcare utilization.	A national cross- sectional in-person Survey (National Health Interview Survey) which primary data was collected by CDC's National Center for Health Statistics between 2010-2016. Quasi-experimental. Data sample was uninsured, low- income participants, ages 19-64, who were affect by the Medicaid expansion. Total number of participants: 67,384 and were assigned between treatment (adopted Medicaid expansion) and control group (had not adopted Medicaid expansion). Variables studied: uninsured, Medicaid coverage, no usual source of care, delayed care due to cost, and unmet need for care due to cost for general care.	Since this was a quasi-experimental study and the Medicaid expansion was not randomly assigned, policy changes may have occurred which could have potentially influenced the results.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Levitt, L. (2021). The inequity of the Medicaid coverage gap and why it is hard to fix it. JAMA Health Forum, 2(10), 1–3. https://doi.org/10.1 001/jamahealthforu m.2021.3905	Evidence level V and quality rating Good	HSO Type: Health Insurance Company Research Domain: Adoption of Medicaid expansion The purpose of this article was to discuss the Affordable Care Act and Medicaid coverage gap.	No review question was included but this article explained how the federal government covers 90% of the Medicaid costs for those states that adopted expansion while the state is responsible for covering 10% share of the cost. For those states that did not expand Medicaid and for citizens that reside in these states, they fall under the Medicaid coverage gap. Citizens who are not elderly nor disabled and without children, do not qualify for Medicaid. Hispanics are more likely to be uninsured and is because 59% of those citizens who fall under the Medicaid coverage gap are from ethnic groups.	Integrative review of Medicaid expansion states in which the federal government pays for 90% of the costs while the states 10% share of cost. Regardless of income, adult citizens in non- expansion states do not qualify for this insurance.	Source limitations not included since this was an integrative review of the Affordable Care Act and Medicaid coverage gap.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Lin, Y., Monnette, A., & Shi, L. (2021). Effects of medicaid expansion on poverty disparities in health insurance coverage. Internati onal Journal for Equity in Health, 20(171), 1–11. https://doi.org/10.1 186/s12939-021-01486-3	Evidence level II and quality rating High	HSO Type: Health Insurance Company Research Domain: Non and expansion of Medicaid insurance coverage The purpose of this study was to understand the changes in insurance coverage for nonelderly US adults (ages 26-64).	Hispanics have the highest uninsured rates across the country and factors such as poverty, do influence healthcare access. On states that have expanded Medicaid, people with low socioeconomic status, had higher chances of obtaining healthcare services while being compared to non-expansion states. Medicaid expansion has allowed for there to be a reduction in health inequity by increasing insurance coverage for low-income families.	Public data waived from review by Institutional Review Board at Tulane University. Quasi-experimental design. Cross-sectional national population from 2012-2018. 3.5 million respondents, an average of 97% response rate, and contain socio- economic, and demographic information. Two groups: treatment group (enrolled in a policy) and control group (not enrolled in a policy). Variables: uninsured, expanded, Medicaid expansion. And poverty.	Medicaid eligibility criteria varies across the states; therefore, this study did not evaluate the effects eligibility has on insurance coverage.

Lopes, L., Montero, A., Preside, M., & Hamel, L. (2024). Americans' challenges with health care costs. Kaiser Family Foundation. https://www.kff.org/health-costs/issue- brief/americans- challenges-with- health-care-costs/	Evidence level V and quality rating High	HSO Type: Pharmacy Research Domain: Healthcare and prescription cost challenges The purpose of this report was to provide statistics on healthcare and prescription costs for Americans.	No review question was included but this report stated the following: half of U.S. adults reported having difficulties in affording healthcare costs, one in four Americans have skipped/postpone obtaining healthcare services due to cost, and six in ten uninsured adults or 61% went without medical care due to costs. 48% of insured adults worry about paying for the monthly premium, 41% of adults report having medical debt, and 74% of adults are very/somewhat worried about paying for unexpected medical bills. Half of adults cannot pay for an unexpected medical bill of $500 without going into debt this includes 85% of uninsured and 65% of Hispanics. One in five adults (21%) haven't filled a prescription due to costs, which is 21% for Hispanics and 32% of Hispanics use over-the- counter medication instead. One in ten adults reported cutting pills or skipped doses of medications due to costs which is 12% of Hispanics. One in four (28%) adults reported somewhat/very difficult to afford prescriptions including 33% of Hispanics.	Evaluation on the financial difficulties American experience when affording healthcare services and prescriptions.	Source limitations not included since this was a report that provided statistics on healthcare and prescription costs with an emphasis on uninsured and Hispanics.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
MacGillivray, T. E. (2020). Advancing the culture of patient safety and quality improvement. Methodist DeBakey Cardiovascular Journal, 16(3), 192–198. https://doi.org/10.1 4797/mdcj-16-3-192	Evidence level V and quality rating High	HSO Type: Hospital System Research Domain: Quality of healthcare services, improvement, and fee-for- services. The purpose of this article was to explore how quality of healthcare services can be measured, improved and its' relationship with fee-for-service payment model.	No review question was included but fee-for-service incentivizes healthcare providers to order and complete more tests, procedures, and hospitalizations which in result in higher reimbursement rates. Therefore, the healthcare system is shifting into value-based care to enhance quality of healthcare services and manage costs. To improve quality of care and healthcare services, facilities must follow the following six aims for healthcare reform: safe, facilities must be held accountable for updating systems that will guarantee patient safety, effective, healthcare providers should have access to both, evidence-based medicine and evidence- based practice when making medical decision for patients, patient centered, a holistic approach of care for the patient including costs, risks, and values, benefits, timely/efficient, avoid unnecessary delays, and equitable, each patient should have access to high-quality healthcare services.	This literature review explained how quality of care and healthcare services can be improved by following the six aims for healthcare reform which will ultimately assist in the shift from fee- for-service to value- based care.	Source limitations not included since this was a literature review in which clinical practices were provided on how to improve healthcare services, quality of care and patient safety as well as explain fee-for-services.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
McMaughan, D. J., Oloruntoba, O., & Smith, M. L. (2020). Socioeconomic status and access to Healthcare: Interrelated drivers for Healthy Aging. Frontiers in Public Health, 8, 1–9. https://doi.org/10.3 389/fpubh.2020.00231	Evidence level V and quality rating High	HSO Type: Non-HSO environment Research Domain: Healthcare access and health outcomes with aging adults. The purpose of this integrative review was to explain the relationship between age, socio-economic status, access to healthcare services, and healthy aging.	No review question was included but this integrative review explained how a person's socio-economic status directly affects access and timely healthcare services. Older adults who are wealthy, have better access to care, from preventative to long-term care, which is associated with healthy aging. Poverty decreases access to healthcare services, increases morbidity and mortality. As the population ages and by making necessary changes to the healthcare system, older adults will be able to access high quality healthcare services such as specialists to treat chronic conditions, preventative services for people with intellectual disabilities, as well as a reduction in all-cause mortality.	Integrative review evaluated the relationship of healthy aging, wealth, and access to time healthcare services as the population ages. Socio-economic status does influence if a person is able to afford and have access to healthcare services such as preventative and continuous medical care for chronic conditions.	Source limitations not included since this was an integrative review of how socio-economic status relates to healthy aging and timely access to healthcare services as the person ages.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Oh, H., Trinh, M. P., Vang, C., & Becerra, D. (2020). Addressing barriers to primary care access for Latinos in the U.S.: An agent-based model. Journal of the Society for Social Work and Research, 11(2), 165–184.https://doi.org/10.1 086/708616	Evidence level I and quality rating Good	HSO Type: Doctor's office (primary care services) Research Domain: Hispanics, primary care, and health disparities. The purpose of this study was to evaluate the relationship between being Hispanic, English proficiency and access to primary care services during a 6-month period.	Limited English Proficiency (LEP) influences Hispanics access to healthcare services by limiting patient-provide interaction. Spanish-speaking Latinos were 3.58 times more likely to be uninsured, delayed medical care 1.47 times, 1.40 times more likely to not visit a primary care provider due to high costs and 3.26 more likely to not have a usual source of medical care such as a primary care provider.	This study uses Agent-based modeling techniques to understand primary care access disparities for racial/ethnic groups and correlation studies. 1,000 iterations. Data was obtained from National Health Interview Survey (2018). Random parameters: geographical distance, which is how far Hispanics are from healthcare centers/primary care offices, LEP Latinos seeking care from Spanish-speaking PCP, and Spanish- speaking PCP improves quality of care by increasing patient-provider communication.	A limitation was that the study was based on assumptions and not reality and no data was presented on how Spanish-speaking patients would most likely see care from a non- Spanish speaking provider if a Spanish-speaking was not available.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Parast, L., Mathews, M., Martino, S., Lehrman, W. G., Stark, D., & Elliott, M. N. (2021). Racial/ethnic differences in emergency department utilization and experience. Journal of General Internal Medicine, 37(1), 49–56. https://doi.org/10.1 007/s11606-021-06738-0	Evidence level I and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Racial differences in the utilization of ED's The purpose of this study was to describe Hispanic experience when accessing the ED for an ongoing medical condition.	Of the 3,122 participants, 10% were Hispanic, responded to telephone-only and mixed-mode questions, were younger (18-54 years old), low levels of education, primarily speak Spanish at home, and had a proxy. Hispanics were more likely to visit the ED for an ongoing medical condition, not new, less likely to have a usual source of medical care and visited the ED three or more times in the last six months. While in the ED, Hispanics reported to have better communication with providers, better experiencing when discussing follow-up medical care, recommended the ED, and received medical care from ED's that provided poor care experiences (average 3.5%). Participants who are frequent users of the ED, reported to not having a usual source of care and do meet the medical needs at the ED.	16,006 eligible patients discharged from 50 different ED's were randomly sampled and randomized to one of the survey groups: mail only, telephone only or mixed mode. 20.25% was the response rate resulting 3,122 eligible participants. Six measures were studied: timely care, providers communication, communication about medications, information provided for test results, follow-up care discussion, and ED recommendation. Independent variable: Patient's race/ethnicity. Socioeconomic, demographics, reason for ED visit, arrival by ambulance, self- reported on understanding the importance of timely care, and if a proxy assisted with the survey.	This study had low survey participation (20.25%) indicating the results might differ from other Hispanic experiences in the ED.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Ramirez, N., Shi, K., Yabroff, K. R., Han, X., Fedewa, S. A., & Nogueira, L. M. (2022). Access to care among adults with limited English proficiency. Journa l of General Internal Medicine, 38(3), 592–599. https://doi.org/10.1 007/s11606-022-07690-3	Evidence level II and quality rating High	HSO Type: Hospital Facility; Doctor's Office Research Domain: Adults with limited English proficiency and difficulties in healthcare access. The purpose of this study was to evaluate how individuals who are not fluent in English do have difficulties when accessing healthcare services including communication with medical providers.	Adults with limited English proficiency (LEP) face difficulties in accessing healthcare services due to communication barriers and being uninsured. LEP participants were 9% of the participants or 22.7 million in 2018, more likely to be female, low levels of education, uninsured, live in the south of U.S., Hispanic, married to adults who were fluent in English, and reported not experiencing difficulties in affording medical bills since they did not have a usual source of medical care or established provider visits within the 1-5 years. These adults reported to be overdue for preventative visits, pap-smear test, colorectal cancer screening, cholesterol and high blood pressure check, and flu vaccine. Almost half of adults with LEP (42.7%) lacked a usual source of medical care while being compared to adults (27.4%) without LEP.	Participants: 117,043, adults 18 years and older. Data was obtained from Medical Expenditure Panel Survey, years 2014-2018, 44%-49% participation, and included health insurance coverage, access and utilization of healthcare services, demographics, and health history. Participants were assigned by age groups (18-64 and 65 years old and older) and with LEP or without LEP. Multivariable logistic regression models were used to analyze the association between LEP, access to care and sociodemographic status.	The Medical Expenditure Panel Survey is a self-reported survey which can often not have correct information from the participants including bias and/or withhold useful information.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Scott, K. W., Scott, J. W., Sabbatini, A. K., Chen, C., Liu, A., Dieleman, J. L., & Duber, H. C. (2021). Assessing catastrophic health expenditures among uninsured people who seek care in US hospital-based emergency departments. JAMA Health Forum, 2(12), 1–12. https://doi.org/10.1 001/jamahealthforu m.2021.4359	Evidence level II and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Uninsured patients who utilize the ED for a treat-and-release visit often face high medical bills. The purpose of this study was to understand how being uninsured does influence ED utilization resulting in higher financial risk.	Out of the total number of studied visits, 51.1% were male, 48.9% were female, 42.4 were low- income, ages were from 20-44 years old, live in the south, and only 9.3% were high income patients. Costs: In 2016, a single ED visit cost $842 while in 2017, $2,033 (141% increase) and annual household income was estimated to be $65,435 in 2006 while in 2017 there was a decrease by 9%, $59,826. 18% of uninsured patients, treat-and- release visits, were at risk of receiving an ED bill and 28.5% met the criteria for health expenditure which is when charges exceed 10% of the annual income. This risk was at 13.6% in 2006 and increased to 22.6% in 2017 (66% increase).	Data was obtained from, Nationwide Emergency Department Sample, 2006-2017, 184.6 million visits, including ED utilization, treat-and- release visits, uninsured patients, demographics, income, and hospital location. Catastrophic health expenditure was measured by survey- weighted linear regression models with year fixed effects to adjust for changes in data.	This study did not include race nor ethnicity; therefore, further studies will need to be completed to understand the disparities ED utilization for treat-and-release visits and catastrophic health expenditure.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Shenoy, A., Shenoy, G. N., & Shenoy, G. G. (2022). The impact of EMTALA on Medical Malpractice Framework Models: A Review. Patient Safety in Surgery, 16(1), 2–7. https://doi.org/10.1186/s13037-022-00325-w	Evidence level V and quality rating Good	HSO Type: Hospital Facility (emergency department) Research Domain: Integrative review of Emergency Medical Treatment and Labor Act (EMTALA) The purpose of this article was to describe the purpose of EMTALA, which government agencies manages this Act and two malpractices.	No review question was included but in 1986 congress established Emergency Medical Treatment and Labor Act (EMTALA) to allow patients to access healthcare services in the ED regardless of ability to pay, enforces for patients to receive medical screening, stabilize the patient, and/or appropriate transfer to another facility due to emergency medical condition. Three government agencies enforce EMTALA: Office of Inspector General (imposes financial penalties), Centers for Medicare & Medicaid Services (manages legal and regulatory development process) and Office for Civil Rights (enforces the laws). Two malpractices with EMTALA. First, is when a physician fails to identify when a patient needs medical treatment and when the health has deteriorated due to not receiving treatment. Second is healthcare pricing which can be fee-for-service or volume-based-fee-for-service reimbursements.	Integrative review discussed the purpose behind the enactment of EMTALA, the government agencies who manage this Act with its influence on payment models and physician decision making.	Source limitations not included since this was an integrative review of EMTALA describing how this Act is managed by the government and malpractices.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Singer, A. J., Thode, H. C., & Pines, J. M. (2019). US emergency department visits and hospital discharges among uninsured patients before and after implementation of the affordable care act. JAMA Network Open, 2(4), 1–8. https://doi.org/10.1 001/jamanetworkop en.2019.2662	Evidence level III and quality rating Good	HSO Type: Hospital Facility (emergency department) Research Domain: Uninsured patients and ED utilization. The purpose of this study was to discuss how uninsured patients living in non-expansion Medicaid states continue to use the ED for healthcare services.	After the implementation of the Affordable Care Act, uninsured patients continue to access healthcare services at the emergency room. Uninsured individuals living in non-expansion Medicaid states have continued to utilize healthcare services in the emergency department and have increased hospital admission rates: 1 in 10 visits and 1 in 20 hospital discharges were made by the uninsured.	Retrospective secondary analysis. Random sampling. Survey data was obtained from the National Hospital Ambulatory Care Survey and Healthcare Cost and Utilization Project (years, 2006-2016) including emergency room visits from 400 hospitals for Medicaid recipient and uninsured individuals, ages 18 to 64.	A limitation of this study is that it analyzes non-expansion Medicaid states as a whole and does not breakdown how insurance expansion influences ED utilization.
Teisberg, E., Wallace, S., & O'Hara, S. (2020). Defining and implementing value-based health care: A strategic framework. Acade mic Medicine, 95(5), 682–685. https://doi.org/10.1097/acm.0000000000003122	Evidence level V and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Uninsured patients, value- based strategies and enhancement in patient outcomes. The purpose of this integrative review was to provide value-based strategies that will benefit uninsured patients, emergency departments and healthcare professionals.	No review question was included but this integrative review explained how emergency departments can align with value- based strategies including: understanding shared needs of patients, design solution to improve health outcomes, integrate learning teams, measure health outcomes and costs, expand partnerships.	This integrative review provided information to be followed by emergency departments, healthcare professionals and community leaders to implement changes that will enhance uninsured patient health outcomes.	Source limitations not included since this was an integrative review that provided value-based strategies to improve patient health outcomes and value in healthcare.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Ukert, B., & Giannouchos, T. V. (2023). Association of the affordable care act with racial and ethnic disparities in uninsured emergency department utilization. BMC Health Services Research, 23(1). https://doi.org/10.1 186/s12913-023-10168-5	Evidence level II and quality rating High	HSO Type: Hospital Facility (emergency department) Research Domain: Racial/ethnic disparities in uninsured ED use and the Affordable Care Act (ACA). The purpose of this study was to analyze how ACA influences the utilization rate for uninsured Hispanics.	Women and Hispanics, residing in large cities, ages 18-34, low income, accounted for the larger score of uninsured ED visits before and after the implementation of ACA. ED remains as a regular access for healthcare services and visits were reported as primary care treatable, non-emergency and injury related. Such preventable visits can be treated at outpatient care allowing for there to be a decrease in gap disparities for uninsured patients.	A retrospective data analysis, years 2011-2017, from Healthcare Cost and Utilization Project and State Emergency Department Databases for non- elderly adults, ages 18-64 including insurance, demographic, ethnic/racial group, and rates of uninsured ED visits. Four states, Georgia, Florida, Massachusetts, and New York, which account for about one-fifth of the US population. Data included three years before ACA and three years after ACA (years, 2011-2013 and 2014-2017).	The data in this study did not provide information on other racial/ethnic groups such as Asian Americans and Native Americans which reduce the generalization of the results.
U.S. Department of Health and Human Services. (2021). Issue Brief No. HP-2021-2 Health insurance coverage and access to care among Latinos. Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/d ocuments/68c78e2f b15209dd191cf9b0 b1380fb8/ASPE_L atino_Health_Cove rage_IB.pdf	Evidence level V and quality rating Good	HSO Type: Non-HSO environment Research Domain: Healthcare access and insurance coverage for Hispanics. The purpose of this article was to provide statistics on Hispanic population in U.S.	No review question was included but Hispanics are the largest racial group, is projected to grown to 25% of U.S. population by 2045, have the youngest demographic group with 31% of Hispanic Americans who were under the age of 18, non-elderly account for 20% of the total population, and 37% for the uninsured elderly population. Out of the total Hispanic population, Mexicans were 60%, Central Americans and Puerto Ricans, 10%, South American 15%, Cuban, and Dominican 5%.	This article analyzed data from multiple sources (years 2013-2019) such as American Community Survey, Census Bureau, and National Health Interview Survey (years 2013-2020) but it did not have a research question, nor participants were aware of the research which is why this is a nonresearch article and integrative review.	Source limitations not included since this was an integrative review that provided demographic statistics for Hispanics in U.S.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Zambrana, E. R., Amaro, G., Butler, C., DuPont-Reyes, M., & Parra- Medina, D. (2021). Analysis of latina/O sociodemographic and health data sets in the United States from 1960 to 2019: Findings suggest improvements to future data collection efforts. Health Education & Behavior, 48(3), 320–331. https://doi.org/10.1 177/10901981211011047	Evidence level III and quality rating Good	HSO Type: Non-HSO environment Research Domain: Changes in demographics for Hispanics. The purpose of this study was to understand the changes in demographics, and sociodemographic health for the Hispanic population.	Hispanics are the largest ethnic minority group, and in 2018 they represented 18.6% and by 2065, they are expected to be at 24% of the total population. U.S. births have the largest population growth for Hispanics residing in southern (41%) and western (38%) parts of the country.	Cross sectional data, longitudinal panel data and longitudinal cohort data for Hispanics. Total of 101 data sets of three 20-year time periods, 1960–1979, 1980–1999, and 2000. Data included Hispanic changes in demographics (growth percentage) and sociodemographic.	A limitation of this study was how cross-sectional data and limited longitudinal analyses had limited data because it did not contain social economic across Hispanic generations which is why causality was not able to be established between variables.

Author, date, and title	Evidence level and quality rating	Focus: HSO type, Research Domain, and Specific Problem being addressed	Findings that help answer the review question(s)	Metrics and Measures if used	Source Limitations
Zhang, J., & Wu, X. (2021). Predict health care accessibility for Texas Medicaid Gap. Healthcare, 9(9), 1–21. https://doi.org/10.3 390/healthcare9091 214	Evidence level I and quality rating High	HSO Type: Health Insurance Company Research Domain: Healthcare information and Medicaid Gap The purpose of this study was to investigate how participants residing in Texas and fall into the Medicaid gap do experience health and demographic disparities.	Demographic disparities of participants who fall into the Medicaid gap were younger (48.8 years old), female (63.7%) and Hispanic (44.7%) Medicaid gap is a barrier that prevents people from obtaining insurance coverage in non-Medicaid expansion states. Those without insurance were twice as likely to have fair or poor health (72.5%), no regular healthcare visits (67.3%), income is higher than the poverty line (26%), but lower for Medicaid eligibility (74.9%). 23.4% reported not being able to see a healthcare professional due to costs, 55% skipped medications, and 20.1% last medical checkup was over a year ago. For chronic conditions, 13.5% had heart disease and diabetes was at 18%.	Data was collected from Behavioral Risk Factor Surveillance Survey; 63,083 cases, 2013-2020, a national wide, random-digit- dial telephone survey containing demographic information, access to healthcare services, and health behaviors. Logical regression and Pearson correlation analysis of dependent variables. Participants were part of the Medicaid gap in Texas from 18-64 years old, living below the poverty line of 138%. Dependent variable=health status, fair, poor, or good health, and 14 independent variables such as demographic, health, education, and economic conditions.	A limitation of this study was pertaining the healthcare statistic since this study had misclassifications on data since samples were higher for Medicaid recipients vs. Medicaid gap.

Appendix D: DHA Thematic Analysis Results

Author(s) and date	Data extracted	Initial codes	Preliminary themes
Agency for Healthcare Research and Quality. (2017). Characteristics of frequent users of three hospital emergency departments. AHRQ. https://www.ahrq.gov/patie nt-safety/settings/emergency- dept/frequent- use.html#discussion	High-frequency emergency department utilization rate: four or more visits in the previous 12 months or three or more prior visits in the previous 3 months or one or more prior visit in the previous 72 hours. 6.7% of uninsured patients do use the ED for non-emergency services. Between 4.5% - 8% are frequent users of the ED counting for 21%-28% of all ED visits.	Emergency Department Overutilization Non-emergency ED visits Frequent and Treat-and-release Visits	
Alnasser, S., Alharbi, M., AAlibrahim, A., Aal ibrahim, A., Kentab, O., Alassaf, W., & Aljahany, M. (2023). Analysis of emergency department use by non-urgent patients and their visit characteristics at an academic center. International Journal of General Medicine, Volume 16, 221–232. https://doi.org/10.2147/ijg m.s391126	Reasons for non-emergency ED visits: primary care services medication refills laboratory tests to obtain a sick leave form headaches/migraines ear/nose/throat infection wound care fatigue upper respiratory symptoms.	Non-emergency ED visits Primary Care Services Treat-and-release Visits	
Al Rifai, M., Mahtta, D., Kherallah, R., Kianoush, S., Liu, J., Rodriguez, F., Nasir, K., Valero, J., Khan, S. U., Ballantyne, C., Petersen, L. A., & Virani, S. S. (2021). Prevalence and determinants of difficulty in accessing medical care in U.S. adults. American Journal of Preventive Medicine, 61(4), 492–500. https://doi.org/10.1016/j.a mepre.2021.03.026	Female (51%) reported difficulties in accessing medical care. Hispanics (17%) reported living below the poverty line, uninsured, unemployed, and did not have a primary care provider. Prevalence of chronic conditions: Hypertension Diabetes Heart Conditions	Demographics – Female Uninsured Hispanics Primary Care Services and Accessibility Chronic Conditions	
Ayanian, J. Z., & Markel, H. (2016). Donabedian's lasting framework for Health Care Quality. New England Journal of Medicine, 375(3), 205–207. https://doi.org/10.1056/nej mp1605101	Factor analysis revealed four measurement standards when measuring quality of care: Prevention Rehabilitation Coordination Continuation of care	Healthcare Quality	

Author(s) and date	Data extracted	Initial codes	Preliminary themes
Ayón, C., Ramos Santiago, J., & López Torres, A. S. (2020). Latinx undocumented older adults, health needs and access to healthcare. Journal of Immigrant and Minority Health, 22(5), 996–1009. https://doi.org/10.1007/s10 903-019-00966-7	Immigrants of Hispanic origin reported delay in healthcare services due to the following reasons: Fear of deportation by disclosing the living address when obtaining care Healthcare costs: Missing a day of work results in earning loss = financial hardship Limited English proficiency results in communication difficulties when seeking care	Immigration Status Uninsured Hispanics Delay in Healthcare Services Financial Barriers Demographics – Language	
Backhouse, A., & Ogunlayi, F. (2020). Quality Improvement Into Practice. BMJ, 638, 1–6. https://doi.org/10.1136/bmj .m865	Quality improvement initiatives: Primary intent: identifying the healthcare aspect that is to be improved Employing and testing: theory and hypothesis Methodology: quality measurement tools Empowerment: quality improvement by healthcare professionals' engagement Data evaluation for future system and process improvement Adapt new quality improvement changes	Healthcare Quality	
Biese, K., Lash, T. A., & Kennedy, M. (2022). Emergency department care transition programs— value-based care interventions that need system-level support. JAMA Network Open, 5(5), 1–3. https://doi.org/10.1001/jam anetworkopen.2022.13160	For disadvantaged populations, value-based care programs prevent unnecessary ED visits, enhances quality of care, encourages coordinated medical care, and decreases healthcare costs.	Value-based Reimbursement Strategies Emergency Department Overutilization	
Bornais, J. A. K., Crawley, J., & El-Masri, M. M. (2020). One stop: Examining the reasons patients use the emergency department for Nonurgent Care and the barriers they face. Journal of Emergency Nursing, 46(2), 163–170. https://doi.org/10.1016/j.je n.2019.08.007	Reasons for non-emergency ED utilization: Primary care providers referral to ED for medical care ED provides efficient care since an appointment does not have to be scheduled ED provides timely and faster medical care (2-3 hours) Easy access to all healthcare services in one visit Three healthcare accessing barriers outside of the ED: Not having a usual source of care such as primary care provider Uninsured patients and lack of affordability at outpatient clinics/private facilities -One problem per visit rule results in multiple in-office visits which is not efficient	Treat-and-release Visits Primary Care Services and Accessibility Non-emergency ED visits Uninsured >Financial Barriers	
Cairns, C., Ashman, J. J., & King, J. M. (2023). Emergency Department Visit Rates by Selected Characteristics: United States, 2021. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/ data/databriefs/db478.pdf	33 per 100 visits is the national average for hospital utilization rates 36 per 100 visits for uninsured Hispanics	Uninsured Hispanics Emergency Department	

Author(s) and date	Data extracted	Initial codes	Preliminary themes
Centers for Medicaid and Medicaid Services. (2021). Quality measurement and quality improvement. CMS. Retrieved from https://www.cms.gov/Medi care/Quality-Initiatives- Patient-Assessment- Instruments/MMS/Quality- Measure-and-Quality- Improvement-#:~:text=CMS%20uses%2 0quality%20improvement %20and,burden%20on%20 clinicians%20and%20provi ders.	Quality improvement: Identifies healthcare gaps in the population Implements outcome-based measures Enhances patient's healthcare outcomes Patients can use quality measures to select providers and providers to evaluate their own medical performance.	Healthcare Quality	
Choi, N. G., DiNitto, D. M., & Choi, B. Y. (2020). Unmet healthcare needs and healthcare access gaps among uninsured US adults aged 50-64. International Journal of Environmental Research and Public Health, 17(8), 2711, 1-12. https://doi.org/10.3390/ijer ph17082711	Analysis of uninsured adults, ages 18-64, reported the following: - having two of more chronic conditions delay in accessing healthcare services due to being uninsured financial distress due to out-of-pocket healthcare costs two-thirds of adults were employed within the last year and still lived below the poverty line	Chronic Conditions Uninsured Hispanics Financial Barriers Delay in Healthcare Services Medication Costs	
Cobb, S., Bazargan, M., Assari, S., Barkley, L., & Bazargan-Hejazi, S. (2022). Emergency department utilization, hospital admissions, and office-based physician visits among under- resourced African American and Latino older adults. Journal of Racial and Ethnic Health Disparities, 10(1), 205–218. https://doi.org/10.1007/s40 615-021-01211-4	Evaluation of Foreign-born older Latino revealed having uncontrolled medical chronic conditions because of living in underserved areas, not having a usual source of medical care, and low access to primary care services. Foreign-born older Latino reported frequent use of ED for respiratory and circulatory medical conditions due to less access to office-based medical visits. a	Immigration Status Chronic Conditions Delay in Healthcare Services Emergency Department Overutilization Frequent and Treat-and-release Visits	
Cronin, A. O., Morton, D. J., Brennan, J. J., & Castillo, E. M. (2020). Frequent emergency department visitors associated with a pain- discharge diagnosis. The Journal of Emergency Medicine, 59(3), 357–363. https://doi.org/10.1016/j.je mermed.2020.06.058	Frequent ED utilization can be defined as six or more visits during the last year. Frequent ED users account for 40% of ED visits in rural hospitals. Average age of ED visits were 34-54 years old.	Emergency Department Overutilization Frequent and Treat-and-release Visits Demographics – Age	

Author(s) and date	Data extracted	Initial codes	Preliminary themes
de Silva Etges, A. P., Liu, H. H., Jones, P., & Polanczyk, C. A. (2023). Value-based reimbursement as a mechanism to achieve social and financial impact in the healthcare system. Journal of Health Economics and Outcomes Research, 10(2), 100–103. https://doi.org/10.36469/00 1c.89151	Fee-For-Service Model: Reimburses the healthcare professional without quality measures and consideration of patient's quality and overall health. Value-based Reimbursement Strategies: Financial incentives are given to healthcare professionals that delivery high-quality healthcare access while at the same time, maintaining healthcare costs. Two payment approaches: Capitation payment: fixed payment amount given to providers who deliver coordinated care over an extended period Bundled payment: payment is completed up front for delivering healthcare services to patients.	Healthcare Payment Models Healthcare Quality	
Dhollande, S., Taylor, A., Meyer, S., & Scott, M. (2021). Conducting integrative reviews: A guide for novice nursing researchers. Journal of Research in Nursing, 26(5), 427–438. https://doi.org/10.1177/174 4987121997907	Integrative review is the process of analyzing all existing knowledge to be able to evaluate the quality of the data, identify the gap, create research questions, and describe the selected framework.	Integrative Review – Healthcare System Healthcare Quality	
Donabedian, A. (1988). The quality of care. how can it be assessed? JAMA: The Journal of the American Medical Association, 260(12), 1743–1748. https://doi.org/10.1001/jam a.260.12.1743	Donabedian's Conceptual framework, SPO model: Structure: healthcare facility Process: delivery of healthcare services Outcome model: patient outcomes	Healthcare Quality	
Drake, P., Tolbert, J., Rudowitz, R., & Damico, A. (2024). How many uninsured are in the coverage gap and how many could be eligible if all states adopted the Medicaid expansion?. Kaiser Family Foundation. https://www.kff.org/medic aid/issue-brief/how-many- uninsured-are-in-the- coverage-gap-and-how- many-could-be-eligible-if- all-states-adopted-the- medicaid-expansion/	Forty states have adopted Medicaid expansion. Ten states have not adopted Medicaid expansion. 1.5 million uninsured people remain and without insurance options Medicaid gap recipients' income is higher than the Medicaid eligibility Marketplace subsidies not offered to uninsured adults living below the poverty line 97% of adults fall into the Medicaid gap Hispanics are 21%-25% List of non-expansion Medicaid states: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming.	Non-Expansion Medicaid States	

Author(s) and date	Data extracted	Initial codes	Preliminary themes
Escobedo, L. E., Cervantes, L., & Havranek, E. (2023). Barriers in healthcare for Latinx patients with limited English proficiency—A narrative review. Journal of General Internal Medicine, 38(5), 1264–1271. https://doi.org/10.1007/s11 606-022-07995-3 Garfield, R., Orgera, K., & Damico, A. (2019). The Uninsured and the ACA: A Primer. The Kaiser Family Foundation. Retrieved from https://files.kff.org/attachm ent/The-Uninsured-and- the-ACA-A-Primer-Key- Facts-about-Health- Insurance-and-the-Uninsured-amidst- Changes-to-the- Affordable-Care-Act	Limited English proficiency is a healthcare barrier for Hispanics. Limited English proficiency = poor care, confusion and frustration when accessing healthcare services without an interpreter. 25% of Hispanics reported difficulties when scheduling medical visits due to language barrier 29% of Spanish speaking patients did not receive medical resolution even after a medical appointment	Demographics – Language	
	Uninsured adults postpone healthcare services > chronic medical conditions > negative health consequences Uninsured adults, living in non-expansion Medicaid states, do not qualify for the Affordable Care Act by having an income above the set limits, and lack insurance access through the employer.	Affordable Care Act Uninsured Delay in Healthcare Services	
Han, J., Zhang, Y., No, G., & Urmie, J. (2020). Medication adherence among chronic condition patients in the Medicaid coverage gap. Research in Social and Administrative Pharmacy, 16(7), 982–986. https://doi.org/10.1016/j.sa pharm.2019.11.011	Analysis of uninsured adults, residing in Southern states and living in poverty yielded these results: Majority were females Had three or more chronic conditions Used seven prescribed medications Frequent use of office-based appointments > six times or more Low percentage (48) had medication adherence	Chronic Conditions Medication Adherence Demographics – Gender	
Hannawa, A. F., Wu, A. W., Kolyada, A., Potemkina, A., & Donaldson, L. J. (2022). The aspects of healthcare quality that are important to health professionals and patients: A qualitative study. Patient Education and Counseling, 105(6), 1561–1570. https://doi.org/10.1016/j.pe c.2021.10.016	Six components of high-quality care: Safety: harm prevention Effectiveness: knowledge Patient centeredness: responsive to patient needs Timeliness: diminish wait times Efficiency: avoids waste Equity: no prejudice and bias	Healthcare Quality	
Hsuan, C. (2023). Improving hospital transfers: A step toward equitable, patient-centered acute care. Forefront Group, 1–9. https://doi.org/10.1377/fore front.20230913.875025	EMTALA doesn't apply once a patient has been medically stabilized Patient-centered quality and policy programs > patient transfer to other healthcare facilities	Emergency Medical Treatment and Labor Act	

Author(s) and date	Data extracted	Initial codes	Preliminary themes
Jiang, L. G., Zhang, Y., Greca, E., Bodnar, D., Gogia, K., Wang, Y., Peretz, P., & Steel, P. A. D. (2022). Emergency department patient navigator program demonstrates reduction in emergency department return visits and increase in follow-up appointment adherence. The American Journal of Emergency Medicine, 53, 173–179. https://doi.org/10.1016/j.ajem.2022.01.009	56% of ED visits are avoidable 28% increase has been reported for ED utilization 38 billion is allocated for ED spending ED discharge programs were designated to assist underserved populations, such as Hispanics and non-English speaking patients with follow-up care after ED discharge. Such program allows for providers to identify the type of medical care a patient is needing, and coordinators assist with appointment scheduling.	Healthcare Quality Emergency Department Overutilization Healthcare Costs	
Kraus, C. K., Moskop, J. C., Marshall, K. D., & Bookman, K. (2020). Ethical issues in access to and delivery of emergency department care in an era of changing reimbursement and novel payment models. Journal of the American College of Emergency Physicians Open, 1(3), 276–280. https://doi.org/10.1002/em p2.12067	Emergency Medical Treatment and Labor Act was enacted by Congress for patients to obtain medical stability at the ED including screening examination without taking into consideration the cost nor patient affordability. ED's also serve as a medical source for patients without a usual source of medical care to obtain healthcare services including primary care services.	Emergency Medical Treatment and Labor Act Primary Care Services and Accessibility	
Lago-Hernandez, C., Nguyen, N. H., Khera, R., Loomba, R., Asrani, S. K., & Singh, S. (2021). Cost- related nonadherence to medications among us adults with chronic liver diseases. Mayo Clinic Proceedings, 96(10), 2–18. https://doi.org/10.1016/j.m ayocp.2021.02.026	Analysis of medication nonadherence uncovered the following statistics: 1 in 4 patients have liver disease 17% reported cost-related nonadherence 12% skipped medication doses 16% delayed prescription refills 13% took less medications Had unplanned ED visits due to illnesses Patients were younger, uninsured, more likely to be female, and low-income.	Demographics – Female Uninsured Chronic Conditions Medication Costs Medication Adherence	
Lee, H., Hodgkin, D., Johnson, M. P., & Porell, F. W. (2021). Medicaid expansion and racial and ethnic disparities in access to health care: Applying the National Academy of Medicine Definition of health care disparities. INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 58, 1-14. https://doi.org/10.1177/004 6958021991293	After Medicaid expansion, Hispanics delay in care had a decrease of 7.4%, uninsured rates decreased by 6.5% and Hispanics insurance rates increased by 17%.	Insurance Coverage – Insured	
Levitt, L. (2021). The inequity of the Medicaid coverage gap and why it is hard to fix it. JAMA Health Forum, 2(10), 1–3. https://doi.org/10.1001/jam ahealthforum.2021.3905	Evaluation of Affordable Care Act and Medicaid revealed how 90% of Medicaid costs are covered by the federal government while the remainder 10% is covered by the states.	Affordable Care Act	
Lin, Y., Monnette, A., & Shi, L. (2021). Effects of medicaid expansion on poverty disparities in health insurance coverage. International Journal for Equity in Health, 20(171), 1–11. https://doi.org/10.1186/s12 939-021-01486-3	Hispanics = highest uninsured rates in U.S. Employment status, income, education, and marital status influence healthcare access and disparities. Statistics on medication and healthcare costs:	Uninsured Hispanics Affordable Care Act	

Author(s) and date	Data extracted	Initial codes	Preliminary themes
Lopes, L., Montero, A., Preside, M., & Hamel, L. (2024). Americans' challenges with health care costs. Kaiser Family Foundation. https://www.kff.org/health- costs/issue- brief/americans-challenges-with-health- care-costs/	One in four Americans skipped/postpone accessing healthcare services due to costs Six in ten uninsured adults didn't obtain healthcare services due to costs 41% of adults have medical debt 74% worry about unexpected medical bills 85% of uninsured and 65% of Hispanics cannot afford a $500 medical bill without going into debt One in five adults can't fill prescriptions due to costs 32% of Hispanics use OTC instead of prescribed medications 12% of Hispanics skipped/cut medications 33% of Hispanics find it difficult to afford medications	Medication Costs Healthcare costs Medication Adherence	
MacGillivray, T. E. (2020). Advancing the culture of patient safety and quality improvement. Methodist DeBakey Cardiovascular Journal, 16(3), 192–198. https://doi.org/10.14797/m dcj-16-3-192	Healthcare system is being reformed by the change from fee-for-service to valued-based care. Quality can be improved by the following aims: Safe: Facilities are accountable for patient safety Effective: Informed medical decisions Patient Centered: Holistic patient approach Timely and Efficient: Avoid unnecessary delays in medical care Equitable: Equal healthcare access	Healthcare Quality	
McMaughan, D. J., Oloruntoba, O., & Smith, M. L. (2020). Socioeconomic status and access to Healthcare: Interrelated drivers for Healthy Aging. Frontiers in Public Health, 8, 1–9. https://doi.org/10.3389/fpu bh.2020.00231	Socio-economic status affects healthcare affordability, access and timely of services. Poverty influences mortality and morbidity. Healthy aging is associated with a higher socio-economic status, access to high-quality healthcare services and a reduction in all-cause mortality.	Financial Barriers	
Oh, H., Trinh, M. P., Vang, C., & Becerra, D. (2020). Addressing barriers to primary care access for Latinos in the U.S.: An agent-based model. Journal of the Society for Social Work and Research, 11(2), 165–184. https://doi.org/10.1086/708 616	Limited English Proficiency negatively impacts healthcare access for Hispanics by decreasing communication between patient and provider. Spanish-speaking Hispanics were most likely to delay medical care by 1.47 times and be uninsured by 3.58 times.	Demographics – Language Delay in Healthcare Services	

Author(s) and date	Data extracted	Initial codes	Preliminary themes
Parast, L., Mathews, M., Martino, S., Lehrman, W. G., Stark, D., & Elliott, M. N. (2021). Racial/ethnic differences in emergency department utilization and experience. Journal of General Internal Medicine, 37(1), 49–56. https://doi.org/10.1007/s11606-021-06738-0	Racial differences in the utilization of non-emergency ED services provided the following information: Most Hispanics spoke only Spanish and had a proxy Visited the ED for ongoing medical conditions New medical conditions were not reported Did not have a usual source of medical care outside of the ED In the last six months visited the ED three or more times for ongoing medical care of existing conditions	Emergency Department Overutilization Non-emergency ED visits Frequent and Treat-and-release Visits Demographics – Language	
Ramirez, N., Shi, K., Yabroff, K. R., Han, X., Fedewa, S. A., & Nogueira, L. M. (2022). Access to care among adults with limited English proficiency. Journal of General Internal Medicine, 38(3), 592–599. https://doi.org/10.1007/s11 606-022-07690-3	Hispanic adults with Limited English proficiency experience communication hurdles in the healthcare system and by being uninsured. Report revealed that almost half of Hispanic adults lack a usual source of medical care and consequently, are overdue for preventative visits, vaccines, and annual physicals.	Demographics – Language Uninsured Hispanics Delay in Healthcare Services	
Scott, K. W., Scott, J. W., Sabbatini, A. K., Chen, C., Liu, A., Dieleman, J. L., & Duber, H. C. (2021). Assessing catastrophic health expenditures among uninsured people who seek care in US hospital-based emergency departments. JAMA Health Forum, 2(12), 1–12. https://doi.org/10.1001/jam ahealthforum.2021.4359	ED visit cost changes: in 2016, a single ED visit cost $842 while in 2017, $2,033 (141% increase) Patient income changes: an annual household income was estimated to be $65,435 in 2006 while in 2017 there was a decrease by 9%, $59,826. Health expenditure risk: uninsured and treat-and-release visits was up to 18% and 28.5% visits were categorized as health risk expenditure which exceeds more than 10% of the patient's annual income.	Healthcare Costs Treat-and-release Visits	
Shenoy, A., Shenoy, G. N., & Shenoy, G. G. (2022). The impact of EMTALA on Medical Malpractice Framework Models: A Review. Patient Safety in Surgery, 16(1), 2–7. https://doi.org/10.1186/s13037-022-00325-w	Emergency Medical Treatment and Labor Act malpractice: When a healthcare professional does not notice when a patient needs medical care causing for the health to deteriorate.	Emergency Medical Treatment and Labor Act	
Singer, A. J., Thode, H. C., & Pines, J. M. (2019). US emergency department visits and hospital discharges among uninsured patients before and after implementation of the affordable care act. JAMA Network Open, 2(4), 1–8. https://doi.org/10.1001/jam anetworkopen.2019.2662	Uninsured patients continue to utilize the ED for healthcare services, especially when residing in non-expansion Medicaid states due to Medicaid eligibility requirements. Statistic: in 10 visits and 1 in 20 hospital discharges were made by the uninsured.	Emergency Department Overutilization Uninsured Non-Expansion Medicaid States	
Teisberg, E., Wallace, S., & O'Hara, S. (2020). Defining and implementing value-based health care: A strategic framework. Academic Medicine, 95(5), 682–685. https://doi.org/10.1097/ac m.0000000000003122	Value-based strategies including understanding shared needs of patients, design solution to improve health outcomes, integrate learning teams, measure health outcomes and costs, expand partnerships.	Value-based Reimbursement Strategies	

Author(s) and date	Data extracted	Initial codes	Preliminary themes
Ukert, B., & Giannouchos, T. V. (2023). Association of the affordable care act with racial and ethnic disparities in uninsured emergency department utilization. BMC Health Services Research, 23(1). https://doi.org/10.1186/s12 913-023-10168-5	Before and after the implementation of the Affordable Care Act, Hispanic adults, ages 18 to 34 years old, had the highest rate of uninsured ED visits including non- emergency, primary care treatable, and injury related.	Uninsured Hispanics Emergency Department Overutilization Non-emergency ED visits Primary Care Services and Accessibility	
U.S. Department of Health and Human Services. (2021). Issue Brief No. HP-2021-2 Health insurance coverage and access to care among Latinos. Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/d efault/files/documents/68c 78e2fb15209dd191cf9b0b1 380fb8/ASPE_Latino_Heal th_Coverage_IB.pdf	U.S. Hispanic population statistics: Will be the largest racial group by 2045 with a 25% increase Youngest demographic population, age 18 and younger (31%) 37% are uninsured and elderly 20% are non-elderly adults Mexicans is the largest group with 60% followed by South Americans with 15%, Puerto Ricans and central Americans 10% each, and Cuban, and Dominican 5%	Uninsured Hispanics	
Zambrana, E. R., Amaro, G., Butler, C., DuPont- Reyes, M., & Parra- Medina, D. (2021). Analysis of latina/O sociodemographic and health data sets in the United States from 1960 to 2019: Findings suggest improvements to future data collection efforts. Health Education & Behavior, 48(3), 320–331. https://doi.org/10.1177/109 01981211011047	Analysis of 20-year data from 1960–1979, 1980–1999, and 2000 revealed how U.S. births have contributed for Hispanics to have the greatest population increase and reside mainly in the southern (41%) and western 38%) areas of the country. This explains why Hispanics are the largest ethnic group in U.S.	Demographic Changes	
Zhang, J., & Wu, X. (2021). Predict health care accessibility for Texas Medicaid Gap. Healthcare, 9(9), 1–21. https://doi.org/10.3390/healthcare9091214	Demographic disparities for adults in the Medicaid gap: Mostly female, 63.7% Hispanic, 44.7% Fair or poor health, 72.5% No regular medical visits, 67.3% and due to costs 23.4% 31.5% reported having chronic conditions	Uninsured Hispanics Demographics – Female Affordable Care Act	

Appendix E: Donabedian's SPO Model Thematic Concepts Map