


BMJ Open Examining Indigenous emergency care equity projects: a scoping review protocol

Tyara Marchand ^{1,2}, Oluwatomilayo Daodu,³ Ali MacRobie,² Stephen Green-Dowden,⁴ Mary Brindle^{2,5}

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¹University of Calgary Cumming School of Medicine, Calgary, Alberta, Canada

²Surgery, University of Calgary Cumming School of Medicine, Calgary, Alberta, Canada

³Department of Surgery, Alberta Health Services, Calgary, Alberta, Canada

⁴Alberta Health Services Knowledge Resource Centre, Edmonton, Alberta, Canada

⁵Ariadne Labs, Boston, Massachusetts, USA

Correspondence to

Tyara Marchand;
tyara.marchand@ucalgary.ca

ABSTRACT

Introduction Indigenous peoples across the globe face inequitable access to high-quality care. Emergency departments are the first point of access for many Indigenous peoples and are the interface between the individual and the healthcare system. There is a reliance on emergency services due to a lack of primary healthcare, a history of mistreatment from providers and increased disease complexity. As such, a potential place for health equity reform is within these departments and other acute care settings. It is the purpose of this review to determine what projects have occurred that address emergency care inequities in four countries such as Australia, Canada, New Zealand and the USA and explore their successes and failures.

Methods and analysis Using search strategies developed with a research librarian, publications will be identified from indexed databases including Medline, Embase, Web of Science, Cochrane Central, CINAHL and Scopus. Grey literature will also be searched and scanned for inclusion. To be included in the review, articles must describe interventions developed to address Indigenous health equity occurring within emergency care settings. Articles will include both programme descriptions and programme evaluations and be quality appraised by analysing study design and Indigenous research methodologies.

Ethics and dissemination This review does not require ethics approval. This protocol describes a review that attempts to map Indigenous health equity interventions taking place within emergency care settings. It will contribute to Indigenous health scholarship and equity research. Results will be made available in multiple dissemination methods to ensure accessibility by researchers and community members.

BACKGROUND

The state of Indigenous healthcare in colonised countries continues to be a global health concern.¹ The legacy of colonialism and the continued perpetration of indignities and inequities against Indigenous peoples has led to a great divide in health outcomes, including increased mortality and rates of suicide and greater infectious disease burdens.^{1 2} While Canada, USA, New Zealand and Australia are similar in terms of the United Nations Development Programme's Human Development Index, they additionally all have Indigenous

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ The academic team behind this article has over 35 combined years of experience in health equity-oriented research.
- ⇒ This is the first review that attempts to delineate the landscape of Indigenous equity interventions within acute care settings.
- ⇒ Quality scales for Indigenous research methodology, such as the Ways Tried and True Framework, are being employed to help ensure that the research is conducted ethically and is inclusive of Indigenous perspectives.
- ⇒ Patients included in this review are from a single ethnicity, which may limit the scope and applicability to other members of the BIPOC community.
- ⇒ This article focuses on four Indigenous inhabited countries with a shared colonial history, however, there does exist many diverse Indigenous nations not represented within this review.

minorities that have health outcomes that are well below their non-Indigenous counterparts.³ For example, a 2016 Statistics Canada report found that on-reserve First Nation males mortality rate was 6636 deaths per 100 000, whereas the non-Indigenous male mortality rate was 370 deaths per 100 000.⁴ Healthcare access is also a stress point for many Indigenous populations, with Indigenous patients facing barriers both proximal and intermediate in nature. Proximate barriers to healthcare include distance traveled to receive care, bias or prejudice from healthcare providers, education level of patient, and access to healthcare professionals in community.⁵ Intermediate barriers effecting healthcare access include high unemployment rates, lack of culturally competent health systems and policy, colonial foundations of healthcare and systemic racism.^{5 6} Education and occupational status disparities are hypothesised to be due to the structural inequities embedded in these structures, such as education programming deficient in cultural sensitivity and the fallout from reduced education attainment.⁵

The interplay between intermediate and direct barriers to health results in ongoing poor healthcare outcomes for Indigenous peoples.⁶

Emergency departments are a first access point for many marginalised individuals, and they can heighten the inequities many Indigenous peoples face. Indigenous peoples tend to use emergency care more frequently than their non-Indigenous counterparts.^{7 8} Fear or mistrust in western healthcare structures has led many patients to avoid health services and only access care in emergency departments during highly acute situations.⁹ Barriers reported as key reasons for delayed presentations include racism within the healthcare system, unavailability of Indigenous physicians and healthcare staff, and language barriers.¹⁰ Further, Indigenous patients have a higher burden of disease and tend to present with more critical health concerns and suffer from higher rates of comorbidities such as type 2 diabetes, obesity and cardiovascular disease.^{11 12}

Throughout the globe, healthcare inequities within emergency departments have been detailed, with structural issues such as understaffing and overcrowding being key barriers to good care and have been shown to increase implicit bias and stereotyping of marginalised individuals.¹³ Length of stay and triage scores are quality-of-care indicators that can be used to analyse healthcare utilisation. Indigenous patients tend to have a decreased length of stay within the emergency department,¹⁴ with Maori in Australasian ED's being less likely to receive bloodwork, radiography and be admitted for observation.¹⁵ In Canada, First Nations identity has been correlated with lower triage scores when compared with non-First Nations patients when presenting with acute processes such as long bone fractures and acute upper respiratory infection.¹⁶

Overall, however, hospital visits tend to be higher for Indigenous individuals, with some studies reporting rates twice as high as non-Indigenous patients.¹⁷ This disparity in admission rates has been hypothesised to be multifactorial: increased propensity for complex injuries,¹⁸ higher rates of chronic disease¹⁹ and late disease presentations have been named as possible contributing factors.²⁰ There are also greater rates of Indigenous patients leaving the department without being seen, and consequently higher rates of readmission.¹⁰ Worse healthcare outcomes among Indigenous peoples within hospital is also a growing occurrence due to delayed presentation and possible inequitable care within hospital.²¹

A scoping review was chosen to analyse this topic as this method is helpful when trying to investigate complex phenomena.²² This scoping review will aim to map the literature of Indigenous health equity interventions within emergency care settings and identify potential gaps in research. There exists a wide array of research analysing Indigenous health outcomes within emergency departments,^{16 17} however, there exists little research identifying projects or initiatives trying to combat this health inequity for Indigenous patients.

Review questions

The objective of this review is to examine health equity interventions within acute care settings across the globe. Specifically, what are the equity projects occurring within emergency departments designed to serve Indigenous populations? How do these projects work to close health disparities for Indigenous patients?

Eligibility criteria

Population

This review will focus on emergency departments within Canada, USA, Australia and New Zealand. These four countries were chosen as they have a shared history of colonisation and similar economic and social systems,²⁰ with these four countries making top rankings for the United Nations Development Programme's Human Development Index.^{3 23} In addition, these were the four countries who originally declined to sign the United Nations Declaration of the Rights of Indigenous Peoples.²⁴

Intervention

We define Indigenous health equity in relation to health systems as the capability of medical structures to deliver effective and unbiased care to Indigenous patients.^{25 26} These institutions are well positioned to potentially contribute and respond to the determinants of health for Indigenous populations. Using this definition of health equity, we will be analysing interventions (projects and initiatives) that have an emphasis on health equity for Indigenous peoples. These projects may be department wide initiatives or focus on specific training available for emergency medical staff. We will also include any initiatives that attempt to respond to health or structural inequities for Indigenous populations. The types of studies that will be excluded include thesis dissertations, conference papers and opinion pieces.

Outcomes

All healthcare outcomes of Indigenous peoples across Canada, USA, New Zealand and Australia will be considered. This scoping review will include studies that examine projects and initiatives occurring within emergency care settings to address issues of inequity within these four countries. Potential outcomes of interventions include patient perception of care quality, Indigenous patient perspectives and quantitative healthcare measures that will be included such as rates of patients who leave without being seen. Projects using a pan-minority approach will not be assessed, and only Indigenous specific projects will be analysed. In addition, projects that have not moved to implementation phase will not be included.

METHODS

Information sources

The electronic sources that will be used are MEDLINE Ovid, MEDLINE Ebsco PubMed, Scopus, Embase, Google Scholar, CINAHL and Web of Science.

Search strategy

In alignment with the Cochrane Guidelines for systematic reviews,²⁷ our search strategy (see Appendix A) was developed in collaboration with a research librarian and reference lists will be searched for relevant texts. At this time, the research librarian has identified the key databases our search will take place in including Medline, Embase, Web of Science, Cochrane Central, CINAHL and Scopus. In efforts towards respectful and ethical research, we have begun consultation with an additional Indigenous scholar with a background in Indigenous health research during the search strategy creation phase to ensure effective knowledge creation. This consultation will help ensure that there is active effort to include articles with Indigenous authorship, community engagement and participatory action research.²⁸

There will be no date start range limitation and articles will be included from inception to July 2022. The search strategy will occur in a three-phase process. An initial search of PubMed and CINAHL will be completed to identify index terms and keywords. Second, a complete search using identified terms will take place across all databases mentioned above. Lastly, research articles that are found in the original search will additionally have their reference lists searched and potential titles will be screened within Google Scholar and abstracts reviewed for possible inclusion.

Abstracts will be screened from these sources and an additional grey literature search will be conducted to ensure we are able to identify all relevant projects. To adequately search the grey literature, a tailored approach will be employed, which includes customised Google search engines, targeted Indigenous nation websites and national resources focused on Indigenous health. In creation of the Google Custom Search Engine, initial exploratory searches will be conducted to identify resources related to Indigenous health and wellness, such as First Nations Information Governance Center and National Collaborating Centre for Indigenous Health were identified. The final list of identified websites and texts will be compiled by the team's health research librarian, SG-D.

We will be including publications from all languages with relevant non-English articles being translated for review with the use of Google Translator. In the event, an article is unable to be adequately translated the project supervisor MB will be contacted to determine next steps.

Study selection

Using the inclusion criteria above, the screening criteria will be created and piloted on a sample equivalent to 10% of total studies in the screening phase, in alignment with the Agency of Health Research and Quality.²⁹ Two reviewers will initially screen the titles and abstract for possible inclusion. The full-text review will be completed by the same two reviewers. Disagreements will be resolved through open discussion and supervisor review if needed. Cohen's kappa will be used to analyse inter-rater reliability.

Data points

For this scoping review, we will be including these variables in our evidence summary:

1. Study identifiers: author, title, year of publication, journal and country of origin.
2. Study descriptions: research design, target population, quality assessment and theoretical framework.
3. Initiative characteristics: type of intervention, level of intervention.
4. Outcome measures: intervention evaluation, process of care measurements and patient satisfaction.

Data management

These data points will be recorded within an Excel spreadsheet and separated based on type of literature (ie, grey vs peer reviewed). In addition, all references will be uploaded to the reference management software Covidence where they will be stored, screened and reviewed. Duplicates will be removed within Covidence.

Data synthesis

This review will follow the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews checklist.³⁰ A summary of findings table will be created, and successes and challenges of Indigenous health equity interventions will be noted.

Academic publications will be created and submitted to a peer-reviewed journal and conference presentations will be produced out of this work. In addition, community accessible dissemination methods such as main-point pamphlets or digital summary pages will be made available.

Limitations

This review is limited in scope to four countries traditionally inhabited by Indigenous peoples with a shared colonial history; however, we acknowledge the rich histories of Indigenous peoples living within other nations. By limiting the population to Indigenous peoples only, it may restrict the scope of this project and exclude equity projects aimed at serving the larger Black, Indigenous, and People of Colour (BIPOC) community. Projects that are not led or co-led by Indigenous people may potentially not reflect the needs and perspectives of the Indigenous patient population; we have attempted to address the limitation by grading the projects on Indigenous quality scales. It is important to note that due to the nature of Indigenous health project implementation, there may be interventions that are not reported on that we are unable to capture within this review.

Patient and public involvement

No patients involved.

DISCUSSION

While Indigenous health inequities continue to increase, there exists reliable evidence showing that health promotion and equity interventions can positively impact health outcomes within racialised communities.³¹ Acute care



settings are the main point of access to healthcare systems for many Indigenous populations and are adequately positioned to address these inequities.³²

Scoping and systematic reviews that attempt to engage Indigenous health topics have been critiqued as lacking Indigenous methodologies and not representative of Indigenous perspectives.³³ This review attempts to counteract this in four unique ways. First, by grading the quality of articles by both research design and using Indigenous quality scales such as the Ways Tried and True framework.³⁴ Second, we have begun engagement with an additional Indigenous scholar who will provide assistance on the data analysis and dissemination phases of this work. Third, we plan to create methods of dissemination that can be accessed by Indigenous communities such as short summaries of findings and presentation at Indigenous community supported research events. We will additionally be sending our short summary reports to Indigenous health websites in Alberta to display at their discretion. Finally, individuals on the research team are members of communities that are visible minorities in Canada, including Indigenous nations.

Knowing the importance of creating Indigenous health research, the overarching aim of this work is to see what is working on the ground in emergency departments. Identifying the types of interventions that are occurring within the departments that make individuals feel more satisfied and empowered with their care will be uncovered. The implications of this are that it will allow us to see what is already being employed across the globe and may help us revise current projects within our own healthcare system.

Twitter Ali MacRobie @AliMacRobie

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Contributors TM of Okanagan descent conceived the idea of this project, established the research question and methodology, and led the development of the protocol. OD and AM contributed to the methods and gave meaningful contributions to the development and/or editing of the protocol. MB as the supervising author gave project guidance and made invaluable edits to the protocol. SG-D assisted in search strategy development and implementation. All authors have approved the final version of the protocol.

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ORCID iD

Tyara Marchand <http://orcid.org/0000-0003-3809-2345>

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