**Discussion**

The overall results suggest that, when it comes to emergency department length of stay, emergency department boarding time, and rate of patients leaving the emergency department before being seen, hospitals that serve higher rates of non-white patients generally perform worse than hospitals serving lower rates of non-white patients.

Most notably, the independent variable “proportion of Black or African-American patients served” was a statistically significant predictor in all twenty models across the five primary study outcome variables. The significant results persisted despite attempts to control for as many as seven other independent variables. Perhaps the most concerning of these outcomes is that proportion of black patients served is the only race/ethnicity variable significantly associated with emergency department length of stay for psychiatric or other mental health patients. To put this disparity in perspective, with all other independent variables held at national averages, a patient with a psychiatric or other mental health condition who arrives at the emergency department of hospital serving roughly 50% black patients can expect a 20% longer stay (259 vs. 215 minutes) in the emergency department than they would at a hospital serving only 10% black patients. This comes despite research suggesting "black people endure more intense and frequent mental and behavioral health issues than their counterparts, at least in part related to poverty and exposure to racism and discrimination, both of which disproportionally affect minorities" (Noonan, Velasco-Mondragon & Wagner, 2016). This conclusions suggest a pressing need for culturally specific investments in the mental health of Black patients, as well as increased investment in hospitals serving high rates of black patients, and increased awareness of mental health care disparities that disproportionately impact black people.

The results also suggest patients who use the emergency department at hospitals serving high rates of Hispanic or Latino patients are more likely to encounter a poor performing emergency department. Proportion of Hispanic or Latino patients served was a significant predictor of higher levels of all primary study outcome variables, except emergency department length of stay for psychiatric or other mental health patients. Compared to patients in the emergency department of a hospital serving only 10% Hispanic or Latino patients, patients in the emergency department of a hospital serving 50% Hispanic or Latino patients experience 16% longer lengths of stay for admitted patients (288 minutes vs 248 minutes), 7% longer lengths of stay for discharged patients (142 minutes vs 133 minutes), 27% longer boarding times (104 vs. 82 minutes), and an 11% higher rate of patients leaving the emergency department before being seen (1.36% vs. 1.22%).

In addition, proportion of Asian or Pacific Islander patients served is significant predictor of three or the five primary study outcome variables: *AdmitLOS*, *WaitForBed*, and *NonAdmitLOS*. Patients in the emergency department of a hospital serving 50% Asian or Pacific Islander patients are predicted to experience a 17% longer length of stay for admitted patients (301 minutes vs 257 minutes), 8% longer length of stay for discharged patients (146 minutes vs 135 minutes), and a 37% longer boarding time (120 vs. 88 minutes), than patients in the emergency department of a hospital serving only 10% Asian or Pacific Islander patients. This trend of lower emergency department performance among hospitals serving higher rates of Asian or Pacific Islander patients is consistent with other system-wide issues in health care affecting Asian Americans. Despite being relatively well-represented in the health care profession, Asian Americans report significant language barriers when accessing health care (Luthra, 2014). There is also tendency for health care professionals to generalize about the background and values of Asian American patients despite high levels of economic and cultural diversity within the Asian American community (Collins et al., 2002). Such patients would benefit from increased provider awareness of the cultural differences between different Asian American subgroups, as well as more access to interpreters, when needed, to help them better communicate their needs to the provider.

Finally, while proportion of Native American patients served is not a significant predictor of emergency department length of stay, it is a significant predictor of boarding time, and is the most significant race/ethnicity predictor by far of rate of patients leaving the emergency department without being seen. Hospitals serving high rates of Native American patients are far more likely to see a patient leave the emergency department before being seen than other hospitals. The best performing model for *LWBSrate* predicts that hospitals serving 50% Native American patients can expect *2.6 times* more patients to walk out of the emergency department before being seen than a hospital serving 10% Native American patients can. To begin to reverse this trend, governments at all levels, and all other funders of health care should consider diverting additional resources to providers serving high proportions of Native American patients specifically to address the problem of walkouts. According to Patel (2017), some recommended strategies for reducing the number of patients who leave the emergency department before being seen are: building an emergency department team that understands the goals and initiatives from the start, more efficient provider scheduling, increased quality incentives for providers, regular discussion of performance statistics among staff, and strong leadership from medical directors. Depending on the provider, additional cultural sensitivity training for staff may also be warranted.