Factors Associated with Non-Urgent Utilization of the Emergency Department

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FACTORS ASSOCIATED WITH NON-URGENT UTILIZATION OF THE EMERGENCY DEPARTMENT

By

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I would like to dedicate this manuscript in loving memory of my father Daniel Perricone. I know you are proud of all your children and what we have become. We wish you were here to share it with us.
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ABSTRACT

Utilization of the emergency department (ED) for non-urgent visits has become an important topic among healthcare providers and administrators. Non-urgent visits to the ED result in financial and health related problems for those who utilize the ED in this manner, as well as managed care organizations.

There are many influences included in patients’ decisions to utilize the ED for non-urgent reasons. The purpose of this research was three fold. The first purpose was to identify reasons for utilizing a southwest Florida Emergency Department rather than other healthcare services for non-urgent care. The second purpose was to identify common factors among patients seeking non-urgent care in the emergency department in a southwest Florida rural emergency department. The third purpose was to determine if patients who visit a southwest Florida Emergency Department for non-urgent reasons receive less preventative care than national standards.

Results indicated three main reasons participants utilized the ED for non-urgent visits. From a sample of 50 participants, 74% did not have a primary care provider, 54% utilized the ED for convenience, and 48% felt their complaint was urgent enough to come to the ED. Common factors among these participants utilizing the ED included 44% of the participants were self pay and there was a significant association between lack of primary care provider and not having a physical in the past year. A large portion of the sample did not receive preventive care; 64% had not received a physical in the past year and greater then 80% had not had a hearing, vision, or dental exam in the past year.

There needs to be more education and resources in the community. For example, non-urgent clinics in the community need to expand hours and days of operation so services are available in the evenings and on weekends. People seeking non-urgent care could then access other health services in the community instead of the hospital Emergency department.
CHAPTER 1
INTRODUCTION

The Emergency Department (ED) has frequently been perceived by some patients as a medical treatment center where one can enter and receive medical attention, regardless of the urgency of the health condition. There are many reasons people go to an ED for care. An emerging concern for the past 20 years is the appropriateness of ED utilization, not only for patients, but for the ED staff, hospitals, and managed care organizations including Medicare and Medicaid.

The field of emergency medicine started in the 1950s, when physicians were called by the police to come to the scene of an accident to provide treatment to survivors. A designated treatment center within a hospital was soon developed, in which a physician was present, where police could bring seriously injured people. There was not an abundance of emergency medical services (EMS), including EMS vehicles, in the 1950s. Patients brought to the designated places were treated regardless of their health insurance status or ability to pay because of the necessity of their acute care need. This system evolved into emergency care.

Physicians staffing the ED in the 1950s were usually in the field of primary or internal medicine. As the concept of the ED grew and became established in the health care services system, medical practice became more specialized in emergency care. Training of emergency physicians in the 1970s developed into a specialty field. The mission of care given regardless of pay continued. (History of the Department of Emergency Medicine, 2006)

With the development of primary care management, extended hour outpatient clinics, and physician specialties, EDs in the 1980s and 1990s were perceived by healthcare administrators as medical centers solely for the treatment of acute care needs, i.e. emergencies that were not appropriate for an outpatient clinic setting or physician offices. Some patients, though, still utilized the ED for non-urgent care and this practice continues today.

Statement of the Problem

The use of the ED for primary care does not provide stability and continuity in patient care that can be provided through an established primary health care provider for patients. Patients who use the ED for primary care may not have a medical home and thus may lack important preventative services, in addition to discontinuous medical care.
Non-urgent use of the ED is a problem because it does not provide proper management of chronic health conditions and primary health care issues. The ED is organized and structured for the delivery of emergency medicine, not primary care. The emergency physicians are trained in emergent and acute care management, not primary care.

**Significance of the Problem**

Initially, the ED provided care for people with high acuity regardless of their ability to pay. As emergency medicine became a growing field and many EDs expanded, people began to use the ED for more than just emergent illnesses. The growing number of uninsured people in the US may have contributed to more people seeking primary care services at their local ED. Managed care started to limit reimbursement for primary care services in EDs, because use of an ED for non-urgent health care was not cost-effective.

According to the population census as of 2000, the setting of the study which was located in a small community in southwest Florida, included a total population of 6,604 with a mean household income of $25,300 annually. The total Hispanic or Latino population was 1,324. The immigration status of many Hispanics in this community is not known. The mean household income is also much lower in this community than its neighboring cities. Immigration status and income influence the types of healthcare that are available to a population.

It is important people have access to health care services through a consistent primary health care provider. A primary care provider can provide preventive health services and continuity of care since the provider knows the patient and the patient’s health history. Using the ED for non-urgent health care is detrimental to the establishment of a patient relationship with a primary healthcare provider.

**Statement of Purpose**

The purpose of this study is to determine reasons for non-urgent visits to the ED, determine any common factors among patients using the ED for non-urgent care, and determine if patients who use the ED for non-urgent care receive less preventive care. Results of the study may assist in identifying groups that are using the ED for non-urgent care, assist with the development of policies aimed to decrease non-urgent use of the ED, and thereby promote the use of a primary health care provider by these groups.
Theoretical framework

The health promotion model of Nola Pender will be used for this study. Pender stated, “The Health Promotion Model has long pointed to new directions in health care.” (University of Michigan, n.d.) Pender’s model discusses the idea that there are many factors that affect health behavior and choices. The two phases of this model include the decision making and the action phases. (Polit & Beck, 2004) In a question and answer session on a nursing theory link, Nola Pender discussed how she became interested in how people were treated for acute and chronic conditions after the fact of development. She stated, “This furthered my interest in people’s ability to take responsibility, make realized decisions, and engage in competent self care.” (A Nursing Theory Link, n.d.)

The beginning or foundation of interrelated feelings and experiences influence behaviors and thought processes. The thoughts brought about could include ideas of money, benefits, outcomes, and family support systems such as friends or family, or even spiritual thoughts. These will then bring about the action or outcome and how committed they are to their plan. (Health Promotion Model, n.d.) Pender’s Health Promotion Model also reflects the thoughts of the necessity of preventative care. Pender stated, “We cannot let people become ill when we have the means to keep many people well-particularly when problems are environmentally and behaviorally induced.” (University of Michigan School of Nursing, n.d.) People come to the ED for treatment for various reasons, such as lack of health insurance, convenience, true emergencies, or even reasons not urgent but perceived as an emergency. The Health Promotion Model (HPM) is based on seven assumptions, such as: “Individuals seek to actively regulate their own behavior.” (Health Promotion Model, n.d.) Personal influences or past experiences may influence their choices to come to the ED. They may have always come to the ED for care because their parents and friends always did and this is a normal comfortable medical home to them. The HPM also has 14 theoretical propositions. One of these propositions is: “Prior behavior and inherited and acquired characteristics influence beliefs, affect, and enactment of health-promoting behavior.” (A Nursing Theory Link, n.d.) The pattern of ED visits from past family experiences links with this proposition and the following assumption of the HPM which states “Self-initiated reconfiguration of person-environment interactive patterns is essential to behavior change.”(A Nursing Theory Link, n.d.) They also may have psychological or mental health issues where they...
feel they will die if they do not get help right away. Anxiety, depression, and stress are frequent causes of ED visits. The ED may be just convenient, close to their home, and patients know they will be seen regardless of insurance status. Lack of health insurance, transportation and time restraints can be viewed as obstacles for people to obtain healthcare which links to another proposition of the HPM that states “Perceived barriers can constrain commitment to action, a mediator of behavior as well as actual behavior.” (A Nursing Theory Link, n.d.) Many of the HPM propositions and assumptions pertain to the person’s perceived benefit from an action. People may perceive the ED as the quick answer to their health care need. They are in turn missing the full picture of having a primary healthcare provider and completely having their health care needs addressed. Identifying reasons and factors in non-urgent use of the ED is an important component of data collection for this research. The patterns and demographics can be helpful in finding and helping the groups that may need direction for more cost effective and comprehensive health care. Educators, practitioners, and community leaders can find more efficient ways for peoples needs to be met when they understand the client’s decision-making process for healthcare and what motivates them towards the ED for healthcare.

Research Questions
1. What are the reasons for utilizing a southwest Florida rural emergency department rather than other healthcare services for non-urgent care?
2. What are the common factors among patients seeking non-urgent care in the emergency department in a southwest Florida rural emergency department?
3. Do patients who visit a southwest Florida rural emergency department for non-urgent reasons receive less preventative care than national standards?

Terms to be defined
1. Emergency department: “The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. Emergency department personnel may also respond to certain situations within the hospital such as cardiac arrests.” (International Federation for Emergency Medicine, 1991)
2. Rural: “A town that is outside of an urbanized area and has a population of 2,500 or
less. (Vital and Health Statistics of the Centers for Disease Control and Prevention (CDC), n.d.)

3. **Factors**: A distinguishing feature that a person may have such as marital status, race, ethnic, age, or insurance status.

4. **Non-Urgent**: Persons who are able to walk and can wait to be seen or treated (Premier Services, n.d.) Non-urgent visits are visits in which the health issue has the ability to be managed appropriately in an office setting. (Phelps et al., 2000)

5. **Emergency Medicine**: "A field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioral disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development." (International Federation for Emergency Medicine, 1991)

6. **Preventive Care**: “Health care which emphasizes prevention, early detection and early treatment, thereby reducing the costs of healthcare in the long run.” (Plexis On-line Resources: Managed Care Glossary, n.d.)

**Assumptions**

Assumptions include the following:

1. In the interview process, the clients will be truthful with the interview and not fearful of altered treatment in their care since individual interview data will not be shared with the ED staff.

2. The criteria for selection will be followed throughout the recruitment process.

3. The data will be collected thoroughly, entered into a spreadsheet or data file, and analyzed correctly.

**Limitations**

1. The study is specific to the unique population of this southwest Florida community with the Hispanic, rural, and low income population.
2. The sample is a convenience sample and the findings cannot be generalized to the entire population.

**Summary**

This research study will aim to identify common characteristics among people who are frequent users of the ED for non-urgent reasons. The study will also identify the common reasons among the people who use the ED for non-urgent reasons. In addition, the study will investigate if participants seeking non-urgent care in the ED receive less preventive healthcare. The study’s findings may assist in explaining the problem of non-urgent use of the ED and how clients are missing important key factors related to their health care needs. These key findings may show common associations among them which could also assist in identifying patterns among people who utilize the ED for non-urgent visits. The findings may assist in recommendations to decrease non-urgent use of the ED in a rural hospital in southern state. The Pender’s health promotion model will be used as a theoretical framework for this study.
CHAPTER 2
REVIEW OF THE LITERATURE

There are numerous studies that explore how people make decisions about healthcare, and the rational behind the decision making process. Nola Pender’s Health Promotion Model is reviewed in this chapter in regards to research studies on healthcare decisions. This literature review will focus on 1) studies examining why people with non-urgent health problems seek care in the ED; 2) impact of non-urgent care on the ED; and 3) access to primary care with relationship to non-urgent use of the ED.

Theory

Nola Pender’s Health Promotion Model

The Health Promotion Model was selected for the framework of this research due to the assumptions on how a person makes healthcare decisions and the association with factors that influence people to use the ED for non-urgent reasons. Nola Pender’s model implies that people make these healthcare decisions based on feelings, experiences, or past influences in their lives. These also include their past experiences of chronic or acute health conditions which could include mental health problems as well. These factors can influence their healthcare choices which could include the use of a primary care provider and choices for preventive care. There have been many studies which research these factors or influences on person’s choices for healthcare decisions.

Reasons People Seek Non-Urgent Care in the ED

A study by Shah-Canning and colleagues, (1996) conducted in three phases between 1964 and 1993, examined what led people to seek medical treatment in the emergency department instead of receiving treatment for a minor illness from a primary care provider. For the purpose of this study, having a regular source of care and attempting to reach them before going to the ED was considered a coordinated visit to the ED. (Shah-Canning, 1996) Subjects were categorized as coordinated when they attempted to reach their physician or regular source of care prior to visiting the ED, and uncoordinated when they did not attempt to reach their primary care management. The second phase of the study, done in 1976, focused on why people chose to go to the ED despite the flourishing of neighborhood health centers. During the latter phases of the
study, the researchers narrowed their field of interest to pediatric patients in a pediatric emergency department. They collected data qualitatively by surveying a number of families about how they decided to choose the ED for pediatric care. The researchers were particularly interested in whether they selected the ED prior to contacting their regular pediatrician first. The study ultimately showed a growing trend in families seeking treatment in the ED. In 1964, 55% of the families surveyed were categorized as uncoordinated in seeking healthcare. By 1976, the number of families grew to 64%, and by 1993 the number had risen to 72%. (Shah-Canning et al., 1996)

Demographics can often help us determine a segment of the population lacking in education or access to readily available resources. The following study was held in a rural region of Canada, which lacked adequate healthcare options to serve the population. The study examined a total of 1,096 ED visits. (Harris, Bombin, Chi, DeBortoli, & Long, 2004) The visits were rated from one to five by a physician and nurse practitioner; one being non-urgent, five being life threatening. Each subject was required to provide his/her age, employment information, information on their primary medical care, marital status, and gender. In order to help establish a pattern among the users of the ED, the researchers created a chart from the collected data that showed which age groups frequented the ED most often.

The two age groups that most often utilized the ED were between the ages of 41-50 and 61-70. The 0-10 years age group was third in frequency of use. The age groups that used the ED least often were between the ages of 21-30 and 11-20 years. Out of the 1,096 number of cases studies performed, 458 were classified as non-urgent (level 1), 347 were classified urgent (level 2), 227 as urgent (level 3), 65 were classified as very urgent (level 4), and one was life threatening (level 5). (Harris, Bombin, Chi, DeBortoli, Long, 2004)

Education and access to resources are key components when discussing how choices are made in healthcare. However, the emotional component of the decision making process should also be considered. The Health Promotion Model discusses the importance of perceived self including benefits and outcomes. One research study utilized a qualitative study that examined how a subject felt about frequent uses of the ED for care. (Olsson& Hangsagi 2001) In this study, 10 subjects were interviewed in their homes by a social worker from the hospital. The subjects were chosen because of their history of frequent visits to the ED. The subjects, whose ages ranged from 23 to 82, had visited the ED for medical care a total of 102 times in the past 12
months. The social worker asked each subject about his/her life, including social, personal, and health history questions. Each subject discussed their feelings of anxiety with relationship to their conditions. Despite the fact that their medical conditions were relatively minor, such as back pain or anxiety, the subjects still felt as though their ailments were life threatening. Each one of them was able to rationalize why their problem was urgent enough to warrant an ED visit. One reoccurring theme in the study was that the subjects had led stressful lives and had dealt with some type of trauma, disruptive family situations, depression, and alcohol or substance abuse. When these subjects came to the ED for treatment, their anxiety was often made worse because they felt they were not respected because of the nature of their complaints and the frequency of their visits. They wanted the staff to treat their complaints as equally important to the urgent complaints because in their minds, they were of equal importance. (Olsson & Hangsagi 2001).

This theme is also apparent in another study in which included client’s perception of their condition warranting the ED visit but does argue another point. This study utilized a 268 sample survey which was taken from those that had been triaged by the nurse as non-urgent. (Gill & Riley 1996) In this sample, 82% rated their care as urgent and perceived they needed immediate care. This study argued the point that it does not matter if they have a primary care provider, if they perceive their need as urgent they will come to the ED. (Gill & Riley, 1996)

**Impact of Non-Urgent Care on the ED**

Studies have addressed the economic impact of non-urgent use of the ED. For example, one study, (Brandon, 2003), explored a follow up care that would help decrease high costs for repeat ED users. Researchers targeted 16 primary care physicians working in clinics who had patients that frequented the ED. The study utilized quantitative data analysis from information collected in a randomized trial. ED usage was monitored in 100 of the physician’s patients, labeled as frequent ED users. The physicians utilized three methods of intervention, classified as minimal, moderate and maximal intervention. All of these categories of intervention involved some type of follow up after ED visits, either from office staff, a social workers or a physician. The 16 participating physicians were given incentive by certain HMOs for intervening and following standardized protocols for certain illness related treatment methodologies. (Brandon, 2003) The study concluded that moderate intervention was a significant factor in cost reduction of patient’s health care issues. There was also minimal
disruption to the practice of the office, meaning there was only a minimal need for office staff involvement. A moderate intervention was described as follows: “Primary care physicians received the initial list and quarterly updates of their patients on their lists who had an emergency department visit or an inpatient admission or did not follow-up with them in the clinic within 2 weeks of the high-cost encounter.” (Brandon, 2003)

More research on interventions for cost containment includes follow up for clients that have been seen in the ED. Another study, (Pope, Fernandes, Bouthillette, & Etherington, 2000), was conducted to see if care-plans and follow through with case management could make a difference in the patient’s frequency of ED visits. This quantitative analysis of the data was collected from 24 patients who had a history of violent or abusive behavior and chronic medical conditions. In total, the 24 patients visited the ED 616 times the previous year. After case managers implemented individualized care plans for these 24 patients, their total number of ED visits dropped to 175 (Pope, Fernandes, Bouthillette, & Etherington, 2000). The study concluded that the follow up and care plans initiated by the case managers was effective in reducing the number of ED visits.

Ruger and colleagues, 2004 designed a retrospective, cross sectional study involving frequent users of the ED. The study included all of the visits for the year 2001 for a specific ED. Many factors were taken into account in this study. They included payment methods, diagnosis, disposition, complaints and acuity. The study discovered that patients utilizing the ED between 6 to 20 times had Medicaid coverage and not an HMO or PPO. These patients also showed lesser acuity than non-frequent users and less admission dispositions than urgent patients. This study concluded that in most cases frequent ED users are not the truly urgently ill patients (Ruger, Richter, Spitznagel, & Lewis, 2004).

**Access to Primary Care with Relationship to Non-Urgent use of the ED**

The financial aspect also includes children, as there have been an abundance of children being seen in the ED. There are many reasons for parents to take their children to the ED, ranging from family situations to financial issues. These families do not understand that using the ED in place of a primary care provider is not cost effective and is not a way of building continuity of health care for children.

The following study by Grossman, Rich, & Johnson (1998), was conducted to examine whether case management intervention of pediatric patients would be useful in lowering their
amount of frequent ED visits. Families who were surveyed were given follow-up information and access to educational resources. They were also counseled on how to overcome any barriers they may have receiving while receiving medical care and the importance of the continuity a patient gets by consulting a primary care provider rather than the ED. The patients that received counseling had a considerable decrease in health care costs within the period of the study. A follow up survey was conducted two years after the initial study showed that despite the counseling the patients reverted back to frequenting the ED (Grossman, Rich, & Johnson, 1998).

As studies have noted, the patient’s access to a primary care provider is relative to non-urgent use of the ED. The purpose of the following study by Peterson, Burstin, Oneil, & Orav (1998), was to examine non-urgent emergency room visits and how non-urgent visits, correlate with not having a physician. Researchers wanted to test if people sought care for non-urgent conditions in the ED because they did not have a primary care provider (PCP). The research also collected personal and socioeconomic information on the patients to determine what groups would benefit most from obtaining a regular physician. The study concluded that out of the 1,696 participants, 50% of ED visits were categorized as non-urgent. It was also determined that one out of every six patients found in the non-urgent category did not have a regular physician. This study showed that having a regular physician would have significantly decreased the frequency of non-urgent ED visits (Peterson, Burstin, Oneil, & Orav, 1998).

Another study by Stein, AT., Ettarzheim, & Costa (2002), was done to see if clients with a PCP used the ED appropriately, as opposed to those who did not have a PCP. This study utilized a cross-sectional interview of 553 clients in a community’s ED. This study showed that of the 61% total emergent and urgent clients 77% of the sample that had a PCP did use the ED appropriately. This shows use in two studies how a PCP can influence a person’s choice for care in the ED (Stein, AT., Ettarzheim, & Costa, 2002).

**Summary**

In summary, the review of the literature noted benefits of primary care as continuity of healthcare, ensuring proper diagnosis and treatment of a condition which also benefits from a physician that knows the patient’s health history and what treatments have historically worked best for the patient. The literature also noted when patients have a consistent primary health care provider they are more likely to have fewer ED visits.
CHAPTER 3

METHODOLOGY

Chapter 3 will address the design of the study. This chapter includes the subjects, the setting of the study, instrumentation, ethical and privacy issues, and data analysis.

Design

This was a quantitative non-experimental, descriptive study on non-urgent use of the ED. The research analyzed a naturally occurring event with no intervention. (Polit & Beck, 2004). The study identified reasons patients used the ED for non-urgent care and described certain characteristics and demographics of the patients who consented to participate in the study. The data collected included the following variables: gender, marital status, race, age, insurance, income, employment, and educational level. The study described if the participants had less preventive health care than recommended national standards.

Setting

The study took place in a southwest Florida rural ED. Recruitment took place by the researcher in the ED triage area of this 82-bed hospital.

Sample

This population sampled was unique due to its high Latino and Hispanic population as well as a lower annual household income as compared to the neighboring cities. A convenience sample of 50 adult clients was recruited for the study. These participants were all classified by hospital protocol as non-urgent visits. There were no exclusions according to race, gender, income or any other demographic factor other than being under the age of 18 and having a visit that was classified other than non-urgent.

Protection of Human Subjects

In accordance with guidelines in place in the Institutional Review Board at Florida State University, application was submitted for approval (Appendix A) of research to be conducted with human subject participation. Institutional approval (Appendix B) was also obtained through the Chief Executive Officer and Director of Nurses at the facility where the
data were collected. After these guidelines and approvals were met, recruitment and data collection began. The participants were recruited with the assistance of a recruitment script in English or Spanish (Appendix C & D) and identity was kept anonymous with no names or identifiers. The Spanish forms were translated with the assistance of a hospital certified Spanish translator Mydalis Wiley. Consent in Spanish or English (Appendix E & F) was obtained and the procedure thoroughly explained. The information is kept in a locked file cabinet in the researcher’s office at home for a period of 3 years. After the three year period of research completion, the data will be destroyed with a paper shredder.

**Instrumentation**

Instrumentation consisted of two tools which included an interview survey in English or Spanish (Appendix G & H) and a chart abstraction form (Appendix I). The interview survey was developed by the researcher and the researcher’s faculty chair from the National Health Interview Survey (NHIS). The NHIS has been done yearly since 1957 in order to obtain an overview of the US population’s overall health status. The survey interview form and abstract form were reviewed for content validity by professionals within this rural ED. A chart abstraction form was developed by the researcher to record selected data, such as age, sex, marital status, primary and secondary payer, triage code, chief complaint, chronic conditions, and disposition.

**Procedure**

Potential study participants were approached in the ED triage area, after they had been determined by the researcher to have a non-urgent visit. Determination of non-urgency was made by the criteria currently being implemented by hospital policy. (Appendix J) During recruitment, the study was explained to a potential participant by the researcher. When the patient agreed to participate in the study, a consent form was completed. The triage area was a very confidential and private setting which allowed privacy for recruitment and consent. The researcher explained the study and answered any questions they had. Potential participants that consented or refused to participate were assured their care in the ED would not change due to their decision to participate or not.
Data collection consisted of 2 parts: 1.) chart abstraction by the researcher, and 2) interview with participant to explore reasons for use of the ED and demographic characteristics, including access to primary care. The participant was taken to a private area in the ED for completion of the study survey. The participant had a choice to complete the survey him/herself or have the survey read to him/her as a face-to-face interview. It was anticipated that the face-to-face interviews would occur for participants who may have difficulty reading for various reasons or prefer an interview with the researcher.

**Data Analysis**

The statistical analysis of all the data collected included descriptive analyses with frequencies, percentages, and selected measures of association. Research question one used descriptive statistics for analysis and research questions two and three utilized cross tabulations with chi squares. Data analysis was conducted with SPSS software.

**Summary**

This chapter reviewed the design of this study. The setting, unique population, sample, and instruments have also been discussed. The importance of protection of human subjects was addressed.
CHAPTER FOUR
RESULTS

The purpose of this research was three fold: 1) to identify reasons people access the emergency department (ED) for non-urgent visits, 2) to identify any common factors among people who utilize the ED for non-urgent care, and 3) to determine if people who use the ED for non-urgent reasons receive less preventive care. The study utilized an interview tool adapted from the National Health Interview Survey and a chart review form created by the researcher and faculty chair. This chapter presents the results of the data analysis.

Description of the Sample

The sample consisted of 50 clients who presented with non-urgent complaints to the ED for care. All 50 participants were determined non-urgent by the hospital’s current protocol and none were admitted to the hospital by the ED health care providers in the course of the evaluation. They were also eligible for participation since all 50 participants were over the age of 18 years old. Table 1 presents a description of the sample.

The largest percent of age groups seen in the ED was from age 30-39 years (32%), followed by the age group 20-29 years (26%). More than half of the 50 participants were female (58%) and not married (58%). A majority of the participants were white and non-Hispanic. Forty –four percent of the sample had some type of private health insurance, 26% had Medicare/ Medicaid, and 30% were self-pay or had no insurance at all. Each participant identified one main reason why s/he sought treatment in the ED. Table 2 summarizes these 50 main reasons, also known as chief complaints.
<table>
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<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
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</tr>
<tr>
<td>30 - 39</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>40 - 49</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>50 - 59</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>60 &amp; above</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>Female</td>
<td>29</td>
<td>58</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>39</td>
<td>78</td>
</tr>
<tr>
<td>Non-White</td>
<td>11</td>
<td>22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Non – Hispanic</td>
<td>39</td>
<td>78</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>Not Married</td>
<td>29</td>
<td>58</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Payer</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare/Medicaid</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>Self Pay</td>
<td>15</td>
<td>30</td>
</tr>
</tbody>
</table>

n=50
Table 2

Chief Complaint

<table>
<thead>
<tr>
<th>Chief Complaint</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, eyes, ears, neck,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throat (HEENT)</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Injury/ or Musculoskeletal pain</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Cold/ Flu Symptoms</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Gastrointestinal (GI) / Abdominal /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (GU)</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Integumentary</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

n=50

The 50 complaints were classified similarly, according to the system of triage utilized in this institution’s ED, resulting in seven categories. The HEENT complaint was most common at 28%. These complaints consisted of areas that included systems of the head, eyes, ears, throat, and neck. They included the following complaints: headaches, sore throat, or pain or drainage from an ear. Cold/ Flu Symptoms, and GI/Abdominal, GU complaints were all equal at 20%. Of the 50 participants, there were 24 (48%) who reported a chronic health condition. Table 3 summarizes the chronic health conditions.
<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Back Problems</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Headaches</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Ulcer</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>12</td>
</tr>
</tbody>
</table>

n=24

In the sample of 50 clients, there were a total of 24 clients with chronic health issues. The 24 participants with chronic health conditions were all categorized as non-urgent according to the institution’s protocol and none were admitted to the hospital. The category “Other” included all other chronic health issues which each yielded one reported “yes”, such as anemia, arthritis, asthma, kidney stones, neck problems, and vertigo.

**Research Question I: Reasons for non-urgent visits to the Emergency Department**

The first research question identified reasons why clients utilized a rural southwest Florida emergency department for non-urgent care rather than other healthcare services. Figure 1 presents the three major reasons provided by the 50 participants.
Seventy-four percent of the reasons for using the ED were because the participants did not have a primary care provider. The convenience of the ED, which included hours of operation and not needing to schedule an appointment, yielded 54% of the reasons for the visits. The remaining 48% of the reasons was that the client thought the situation was urgent enough to warrant the ED visit and they could not wait for an appointment at a clinic or other health care facility.

**Research Question 2: Common factors among participants**

The second research question explored the common factors among participants seeking non-urgent care. The question aimed to identify any common characteristics among the participants.

Table 4 summarizes two major factors noted among the participants who sought non-urgent care in the ED: lack of primary care provider and no physical in the last year. Information about method of payment is also included in the table.
Table 4
Common Factors

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Primary Care Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(No doctor or nurse practitioner)</td>
<td>38</td>
<td>76</td>
</tr>
<tr>
<td>No Physical in the Last Year</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>Method of Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid/Medicare</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Self pay/no insurance</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>Private</td>
<td>15</td>
<td>30</td>
</tr>
</tbody>
</table>

n=50

Associations were examined between the common factors, reasons for using the ED for non-urgent care, and selected descriptions of the sample. There was a significant association between not having a personal provider and not having a physical in the past year (Chi square = .000, p< .05). There was, however, no significant association between a participant not having a primary healthcare provider and if the participant elected to use the ED due to convenience (Chi square Fisher’s Exact test = .251, p>.05). There was also no significant association between participants not having a primary health care provider and if the person felt their ED visit was urgent (Chi square Fisher’s Exact test = .433, p>.05).

The participants reported a number of chronic conditions as noted in Table 3. Of the 20 participants who reported a chronic condition, 11 had a primary health care provider. The association between having a chronic condition and having a primary health care provider was significant (Fisher’s Exact = .000, p<.05). There was no significance found between the presence of a chronic condition and the other two reasons for electing to choose the ED: convenience (Fisher’s Exact test = .343, p>.05) and urgency (Fisher’s Exact test = .523, p>.05).
There was no significance noted between ethnicity and the participant reporting having a primary health care provider. Significance was found between race and if the participant had a primary health care provider (Fisher’s exact test = .002, p<.05); 34 whites reported no primary health care provider compared to four blacks, from the total sample of 50 participants.

**Research Question 3: Preventive care among participants**

The third research question examined whether the participants received less preventative care than the national standards recommended in the National Standard Preventive Care Guidelines. These standards are set forth by organizations such as the American Heart Association or the American Cancer Society, to ensure providers give adequate health screenings to patients. Table 5 presents data related to preventive health care received by the participants, including variations based on age and gender.

A majority of the participants (>80%) did not have a yearly vision or hearing screening and dental exam. Over 50% reported not having a flu immunization or cholesterol screening in the last 12 months. Seventy-four percent did receive a tetanus shot in the past 10 years. Of the seven respondents over the age of 50, all answered yes to having their stool checked for blood before. Table 6 represents the gender specific preventive health care received.
<table>
<thead>
<tr>
<th>Table 5</th>
<th>Preventive Health Care Received (Compared to National Standards)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td>Vision or Hearing Screening</td>
<td></td>
</tr>
<tr>
<td>In the last twelve months</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>40</td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
</tr>
<tr>
<td>Dental Exam</td>
<td></td>
</tr>
<tr>
<td>In the last twelve months</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>43</td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
</tr>
<tr>
<td>In the last 10 years</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>13</td>
</tr>
<tr>
<td>Yes</td>
<td>37</td>
</tr>
<tr>
<td>Flu Immunization</td>
<td></td>
</tr>
<tr>
<td>In the last 12 months</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>36</td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
</tr>
<tr>
<td>* Stool Checked for Blood</td>
<td></td>
</tr>
<tr>
<td>Over 50 years old</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>Cholesterol Checked</td>
<td></td>
</tr>
<tr>
<td>In the last 12 months</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>34</td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
</tr>
</tbody>
</table>

n=50. * n=7
Table 6
Gender Specific Preventive Health Care Received (Compared to national Standards)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of testicular Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>76</td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Prostate Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If over 50 years old**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Rectal Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If over 50 years old**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Women</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yearly Gynecological Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>62</td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>38</td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If over 35 years old ****</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>63</td>
</tr>
<tr>
<td>Monthly Self Breast Exams***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>26</td>
<td>90</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

* Men n=21. **Men over 50 n=1. ***Women n=29. ****Women over 35 n=19
The gender questions specific to men pertained to 21 participants. Of these 21 men, 76% did not know how to perform a testicular exam. The five men that did report knowledge of how to perform a testicular exam said that they performed the exam once every few months. The only male participant over the age of 50 was the only one who reported that he had previously had a prostate screening and a rectal exam.

The gender questions specific to women consisted of 29 participants. Of the 29 women, 18 (62%) reported they had not had a vaginal exam in the past year. Of the 18 women who had not had the exam in the past year, six said they had an exam in the past 2 years; seven had one in the past 3 years; four had one in the past 4 years; and one had never been examined at all.

**Summary**

The descriptive findings discussed certain demographics of the participants in this survey. The age groups seen most in the ED ranged between ages 30-39. More than half of the participants were not married and a majority were white and non-Hispanic. Thirty percent of this sample did not have insurance and were self-pay. Major reasons for seeking care in the ED were HEENT issues, musculoskeletal injuries, cold/flu symptoms, and GI and GU issues.

Three major reasons were provided for using the ED for non-urgent care. The primary reason sited was lack of a primary care provider. There was a significant association between not having a primary care provider and not having a physical in the past year. Participants with a chronic condition were more likely to have a primary care provider. There was a significant association between race and method of payment; more whites reported no health insurance.

A majority of the participants had no yearly physical exam and lacked notable preventive health such as dental exams, vision or hearing screenings, flu immunizations, and cholesterol screenings. Among male participants, 76% reported lack of knowledge of being able to perform a testicular exam. Among female participants, 66% had not had a vaginal exam in the past year and 90% did not perform breast exams. Strengths in preventive services included a high percentage of participants reporting a tetanus vaccine in the past 10 years, stool checked for blood, and mammograms among women over 35 years old.
CHAPTER FIVE

DISCUSSION

The purpose of this study was three-fold: 1) to identify reasons participants used the ED for non-urgent care, 2) to examine common factors among participants who used the ED for non-urgent care, and 3) to determine if those participants who utilized the ED for non-urgent reasons received less preventive care. The findings are discussed in relation to other major studies, the theoretical framework, implications for nursing practice, and recommendations for resolution of identified problems.

Research Question 1: Reasons for Non-urgent Visits

The 50 participants provided three major reasons for using the ED for non-urgent care. These reasons included lack of a primary care provider, convenience, and the urgency of their complaint. The most common reason was the lack of a primary health care provider (PCP). When the interviewer probed for further rationale for not having a PCP, the most common response from the participants was “I don’t need one”. This reply suggests people are not aware of the importance of having a PCP. People are not considering continuity of care or preventive care but are looking for the “quick fix”.

When the same respondents who do have a PCP were asked where they do go for care, 26 responded the ED, nine responded to a nearby clinic, and 2 to the health department. This shows us that those in the sample set most frequently seek care in the ED for their non-urgent care needs.

The second most common answer to why the ED was chosen for care was that it was convenient. Of the sample (n=50) 27 responded the ED was more convenient. Patients considered the ED to be convenient because it was accessible around their work schedules. The hours the clinic and the health department were open were not convenient and wait periods were too long in offices to get an appointment. People commented, “They can’t fit me in until next week.” This was considered an unacceptable wait time for an appointment, even for a non-urgent issue.

The third most common reason the ED was chosen was that their complaint was urgent and the ED was warranted. Of the sample (n=50) 24 of the clients responded that their complaint was of an urgent nature and that they needed to be seen in the ED. This institution’s protocol for classification of urgency of complaint is a standard protocol utilized by other various institutions.
These clients were all classified as non-urgent but yet truly felt their need was urgent. The reason for this thought process is unclear; however, it indicates the need for education about non-urgent illnesses as well as the establishment and explanation of other options available for this type of care.

For example, including a social worker as part of the ED staff may be beneficial and is common in many EDs. In the institution where the study took place, transition management staff members are available to provide assistance to the ED staff with crisis interventions, Baker Acts, mental health, and homeless issues. The transition management staff can help clients find their way to resources they may not know are available to them. People with mental health conditions such as anxiety and depression can feel that if their chronic back pain is not relieved in the next hour they will die. Even though they may never have relief from the back condition, the thought that they are being taken care of relieves this anxiety. Transition management staff and social workers could assist non-urgent ED patients with mental health issues and provide case management services, assuring linkages to needed community resources.

Non-urgent situations of this type can lead the staff to perceive that the patient’s complaint is not important due to other emergencies that are occurring in the ED at that time. When clients believe their care is unimportant to the staff, despite it being important to them, they tend to become angry and their true anxiety issue can become worse. This could warrant even more ED visits by the client to the same institution or neighboring ones, in hopes of receiving some sense of satisfaction and acknowledgement of their issue.

Research Question 2: Common Factors among the Participants

The study found common factors among people who utilized the ED for non-urgent care. These factors included chief complaints, not having a PCP, age groups, and method of pay.

In findings related to the chief complaint of the participants presenting to the ED, 28% reported HEENT issues, including the following diagnoses: ear aches, sore throats, headaches, and toothaches. Another 20% of the participants reported, cold and flu symptoms as the chief complaint. These findings demonstrate that people use the ED like a clinic for non-urgent health issues.

In collecting the data, some people were reluctant to participate in the interview process. Some clients felt they were too ill to complete the interview process and others felt they did not have time to complete the process because they needed to be seen quickly in the ED, although
they did not have an urgent issue. Only a small number of people refused to participate in the study; they expressed they did not want to delay care, even though they were assured their care would not be delayed and their wait time to be seen could be up to one hour or more.

Although Arcadia’s population consists of a large percentage of Hispanic and Latinos, only 22% of the sample was composed of Hispanic persons. Although there was no significance found in ethnicity in relation to non-urgent use of the ED, it is important not to conclude that Hispanics do not use the ED for non-urgent use or that their health care needs are addressed elsewhere. A study with a representative Hispanic sample is needed to further explore the Hispanic healthcare needs. In addition, although significance was found with race, a representative sample is needed before definite conclusions are made.

As mentioned in research question number one, the majority of this sample did not have a PCP and utilized the ED for their main source of care. The ED was more convenient and sufficed to take care of the client’s needs. An interesting factor was the age groups that more commonly utilized the ED. Participants ages 30 -39 composed 32% of the sample and ages 20 -29 made up 26% of the sample. More than half of this sample ranged from age 20 to 39. One could propose these age groups reflect working adults who do not have access to other health care options for non-urgent care since other health care services are not open after 5 p.m. in the community. A positive finding was that of the 24 participants who reported a chronic condition, these participants all reported having a primary care provider. The problem is that these participants were still using the ED for non-urgent care.

Another common factor was that a large percentage of the participants reported not having health insurance. This finding is not surprising and reflects larger studies documenting the use of the ED for non-urgent care among people without health insurance. There are approximately 47 million uninsured people in America and many do not have a primary care provider. The ED may be the only source of care for the uninsured in this community.

**Research Question 3: Preventive Care among Participants**

The third research question lead to the finding that many of the participants did not have preventive health care, based on national standards. This finding was not a surprise considering that a large number of participants did not have a primary health care provider. In addition, a notable number of participants did not have any health insurance.
The large number of participants who had not had a dental exam in the past year was not surprising because oral health is an area least addressed by many people in America, particularly in rural areas. Interestingly, at the end of the interview there was a question regarding what type of health care they would like to receive that they did not get. Out of the few responses received, the only answer was “dental care.”

Of the 50 participants, 37 clients reported having a tetanus shot in the past 10 years. There was common knowledge that Tetanus was a serious illness and most had admitted to some type of injury they felt required this injection. When the participants were asked about receiving annual flu immunizations, 36 responded “No”. Some of the participants answered they had a flu immunization once and became sick, so they do not get them. Knowledge that this injection will help combat the severity of symptoms and lessens the chance of contacting the more common strains was not known.

Interestingly, there were many non-urgent ED complaints related to cold/flu symptoms. Another interesting finding was the number of people who stated that they had not had their cholesterol checked in the past year. Only 16 participants responded “Yes” to being tested although cholesterol screening is recommended every five years for everyone ages 18 and above, and sooner if risk factors are present. The participants were all above the age of 18 but many were not interested in this screening for reasons such as, “I eat well,” “I have no problems in my family,” or “I feel fine.” Again, we can see the need for education. People may not fully understand the condition of hyperlipidemia, risk factors and future consequences of not having this preventive care screening. A source of payment for screening is needed, especially since a sizable number of participants lacked health insurance and a primary health care provider.

Screening for gender specific issues also yielded notable findings. Self testicular exams are recommended for all male adults age 18 and above. A majority of the males reported not knowing how to perform this exam or having attempted to do it. This is an important finding and very pertinent to men’s health. This type of cancer in males can have a very good prognosis if found early, and unfortunately very poor if found late. In females Pap smears are recommended yearly after age 18 or sooner with risk factors. Of 29 women, 19 said they had not had a pap exam in the past year, but there was one client who had one just over 1 year. Only one woman never had one. She was 22 years old and felt it was not necessary because of her young age. When women over the age of 35 were asked about having mammograms 63% said they had had
one. This finding was positive considering the lack of health insurance among most of the participants. This may reflect that women are accessing programs available to women without insurance to obtain mammograms. When women were asked if they performed self breast exams, 90% said “No”. Some of the reasons for the lack of self breast exams included, “They say your partner will pick it up,” “Usually, I would feel it if something were there,” “Everything looks fine,” and “I’ve never had a problem before.”

National standards for preventive care are well known among primary care providers. When people do not have a resource to educate and direct them to preventive care, then they may not think prevention is necessary. Financial burdens in households can result in preventive care placing last on the list of expenditures. People may not view preventive care as medically necessary and will wait until there is a problem to seek care.

Many people have the thought process, “Why fix what is not broken.” In addition, lack of health insurance is a barrier to primary care and a large number of the participants lacked both health insurance and a primary care provider. Many people cannot afford to purchase their own private health insurance if the benefit is not provided at work. These findings strongly indicate not only the need for education about preventive care, but also the need for a primary health care provider, the ability to obtain health insurance, and also the establishment of resources in the community for non-urgent care.

**Relationship to Literature**

The findings for this study do support the findings in this literature review. The study by Shah – Canning (1996) discussed the trend of coming to the ED, rather than utilizing a PCP, by pointing out that one out of every six clients seeking non-urgent care in the ED did not have a PCP. The findings of this study support the abovementioned study since 74% of the sample did not have a PCP.

The literature review also discussed the idea of a client’s perception of their condition. The study by Olsson & Hangsagi (2001) showed that 48% of the sample felt their complaint was urgent enough to seek care in the ED. Anxiety and mental health issues are factors that could influence clients choosing the ED. Another study in the literature review discussed how a patient’s perception of their ailment prompted them to seek care in the ED even if they had a
PCP. (Gill & Riley, 1996) This study also found that participants with primary care still sought care in the ED, possibly due to convenience and a sense of urgency regarding their condition.

Theoretical Framework and Related Findings

The Health Promotion Model of Nola Pender gives insight to the many thought processes that people use when making decisions regarding their health care. There are many influences on people’s healthcare choices, including benefits they perceive to them. Nola Pender discussed that their previous experiences, psychological or social affects could all include these influences. Nola Pender has had interest in preventive care, specifically why acute and chronic conditions are commonly treated after they occur rather than using the readily available means for prevention.

In discussing influence on choices for healthcare this study showed that 48% of the participants truly believed their complaint was urgent enough to warrant the ED visit. They believed they were in the correct place to receive care for their ailment. Interestingly, the major chief complaints were HEENT and Colds/Flu symptoms which are non-urgent. A person’s psychological state and or lack of primary care provider could influence using the ED for these two non-urgent issues. The health promotion model states that people’s beliefs are a large influence on their choice of healthcare.

The decision on preventive care can be thought of as a perceived benefit to a person by the condition of their future health status. This study however indicated a small amount were actually receiving preventive care: 74% did not have a PCP; only 14% had dental exams; 68% had not had their cholesterol checked; and the males and females did not commonly perform self exams as recommended by national standards. People may not see this as type of care as a benefit, but a luxury. The “quick fix” of the ED is really the perceived benefit.

Patients with chronic conditions were however more likely to have a PCP and their perceived benefit may be related to management of the chronic condition as opposed to a quick fix. These people may have been educated on the importance of management after being diagnosed with their condition. However, we do not know if they had a PCP before they were diagnosed or if it was found by chance and then they acquired their PCP.
This study identified choices people make for seeking health care in the ED and possible influencing factors. The social, psychosocial, or familial influences may not be leading them to the best choices available, assuming other options are available.

**Implications for Nursing**

The nursing field has many areas to assist in this significant problem of non-urgent utilization of the ED. Two of the most profound areas of implication are education and resources.

People need education in many areas of healthcare; from standard, general health practice to chronic health care management. People need to understand what preventive care means and what is included such as immunizations and preventive care screenings. There are many groups that are currently not immunizing their children for fear of conditions such as ADD from synthetic products in the preservatives. People need to be educated on the risks of not immunizing as well as not having preventive screenings, which can be just as detrimental. People need to be aware that just because they feel good does not mean that nothing is wrong. There are silent killers such as heart disease, and all the various cancers, some of which can be easily treated and managed if caught in time. Education is also needed on the importance of having a primary care provider.

Education is needed regarding the community resources available to clients. The nursing or medical staff in the ED is the front line for this education. The non-urgent people coming to the ED need to be told about the other resources available to them. Currently in the hospital ED waiting room, there are brochures and charts on various resources in the community. People may not take the time to review them but the nursing staff needs to make it their responsibility to make patients aware. There is a general fear among the ED staff when it comes to turning a client away for a non-urgent complaint, therefore all patients are seen regardless of the nature of the complaint. This fear of turning non-urgent patients away is related to liability and the possibility of the patient’s condition becoming more serious. There is a new policy in the hospital that states all patients will be triaged, but the ED physician has the right to not see the patient with a non-urgent complaint in the ED. They will be referred to other resources. This is becoming a trend in neighboring counties as well. One neighboring county has incorporated non-urgent clinic referrals from their ED as part of non-urgent utilization management. HMO’s and other pay organizations are on the trend of not paying non-urgent ED bills. Various EDs are also
utilizing a sliding scale pay to collect for their visits. These are all ways to deter clients from non-urgent visits. Though various programs are currently being implemented, education of the type of care needed should still remain as the main focus. If people are turned away, they still need to know where to go.

Clients are often not aware about prescription programs through churches such as St. Vincent DePaul, and volunteer primary care provider programs including cardiology programs that accept a certain number of clients per year for free. There are also various dental clinics who take sliding scale income for pay. The health department currently has a financial screening program for clients. If they fall within a certain income category a substantial portion of their care could be free or given at a reduced rate. The program also provides preventive care and screenings. People need to be made aware of these programs for their own benefit and to improve future health care access in their family’s care as well. Community education can also be done by mobile vans going into the communities to give out the information and to speak with the people in the local areas. There is currently a mobile van which is utilized by a group of physicians in a neighboring county, which also initiated a community outreach program this year.

The clinics available for non-urgent care including the health department should expand the hours of operation. Most offices and clinics are open Monday through Friday 9-5 during work hours. The findings for this study implied that the ED was convenient since the ED was available after work and in the evening. If care was available in the evening hours clients would have another option. Presently Wal-mart is implementing a program where there will be providers in a designated area for non-urgent care; it will be interesting to study the outcome of the new service in relation to non-urgent use of the ED. Nurse practitioners could be a benefit in the implementation of a non-urgent clinic These providers are trained in care that includes preventive care and screening and are an excellent resource for clients. Many of these non-urgent clinics run by nurse practitioners are already utilized in neighboring communities

**Recommendations for Future Research**

This study could have incorporated a question specific to any mental health condition including depression or anxiety or post-traumatic stress disorder, PTSD. Even though participants were asked about chronic conditions, mental health conditions may have not been
revealed to the interviewer or may not even be diagnosed in participants for various reasons. Future studies could include a larger representative sample.

Future studies of non-urgent utilization for the ED could include outcome evaluation studies after certain interventions, such as referrals and case management services within the ED, are implemented.

In future studies, income and education levels could be included and examined in relation to non-urgent use of the ED. Data as to why clients were self pay, what their financial status was, and where healthcare ranked in order of their financial concern could be helpful.

Research questions to be asked could include: If you had to purchase a $50 breathing machine and medicine to utilize it, would you be low on food for the month? Do prescription refills affect your ability to purchase food and house supplies? Do you not take medicine at times when needed because you don’t have the money to get the medication? A more detailed analysis of the client’s finances should be incorporated into a future study. This would allow us to see whether health care decisions were based upon lack of knowledge/resources or simply the need to remain within a certain budget in order to survive. These types of future studies may be helpful for prescriptions, supplemental, and preventive governmental health care programs.

Future research could also include whether people know what the national guidelines are for preventive screenings; what they are; why they are important; why PCPs are important; and what their role is. It would be helpful to see how much people know about preventive health care and what educational needs still need to be addressed. These could include asking clients about their resources in their community. It would be beneficial to know if they know what is out there, how to access it, and why they need it.

**Summary**

This research study has identified reasons for using the ED for non-urgent care, in a rural community in southwest Florida, in addition to common factors among the study participants and overall lack of preventive health care. People face many factors that influence their decisions to seek healthcare, as noted in Pender’s Health Promotion Model. This non-urgent utilization of the ED is a detriment not only to the hospital in terms of costs, but most importantly to the clients who use the ED for non-urgent care because of not having a primary health care provider. As healthcare advocates, the nursing profession has a responsibility to address the issue of non-
urgent use of the ED and the broader health policy issues associated with non-urgent use. These
broader policy issues include the large number of Americans without health insurance and the
subsequent barrier in accessing primary care. Important considerations include client education
and the availability of community-based resources for primary care.
APPENDIX A

FLORIDA STATE UNIVERSITY IRB APPROVAL
Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8933 - FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 12/7/2006

To:
Mary Frances Scott
20110 Holland Avenue
Port Charlotte, FL 33982

Dept.: NURSING

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
Factors Associated with Non-Urgent Utilization of the Emergency Department

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on 11/8/2006. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by 11/7/2007 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. The principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: Dr. M.B. Zeni
HSC No. 2006.0978
APPENDIX B

INSTITUTIONAL APPROVAL LETTER
September 5, 2006

Mary Scott, RN
Graduate Student FSU

Dear Mary,

Permission is hereby granted to conduct the research necessary for your thesis: Factors Associated with Non-Urgent utilization of the Emergency Department.

Subjects will be identified and informed consent obtained prior to any data collected.

I appreciate your commitment to the profession.

Sincerely,

Beverley Winston

Beverley Winston, RN, MSN, MBA, CNAA-BC
Vice President Patient Care / Chief Nursing Officer
Hello, my name is Mary Scott. I am a graduate student at the Florida State University College of Nursing. As part of my school work, I am doing a research study about where people go to get health care.

I would like to talk with you for about 15 minutes. We will talk about your health care and what health care you may have had this past year. Your participation in this study is voluntary. If you choose not to participate or withdraw from the study at any time, there will be no penalty; this means whatever you decide, will not affect your care. The results of my study may be published, but your name will not be used.

Are you interested in talking with me about health care?
APPENDIX D

RECRUITMENT FORM SPANISH
Hola, mi nombre es Mary Scott. Soy una estudiante de postgrado del Colegio de Enfermería de la Universidad Estatal de la Florida. Como parte de mi trabajo estudiantil, yo estoy haciendo un estudio de investigación acerca de donde las personas van a obtener asistencia médica.

Me gustaría hablar con usted por unos 15 minutos. Hablaremos acerca de su cuidado de salud y que tipo de cuidado de salud usted ha tenido este año pasado. Su participación en este estudio es voluntaria. Si usted no desea participar o desea retirarse después de haberlo comenzado, usted no será penalizado; esto quiere decir que la decisión que usted tome, no afectará su cuidado. Los resultados de mi estudio pueden que sean publicados, pero su nombre no será usado.

¿Está usted interesado de hablar conmigo acerca del cuidado de salud?
Informed Consent Form

Factors Associated with Non-Urgent Utilization of the emergency department.

I have been informed that Mary Scott, RN, BSN, has requested my participation in a research study that is part of her course work at Florida State University College of Nursing.

The purpose of the research is to study reasons people use the Emergency Department of a local hospital. The research may help the hospital plan services for people in the area. There will be a total of 50 people who volunteer to discuss reasons for using the Emergency Department for health care.

My participation will involve an interview and will take about 20 minutes. The interview will be done by Ms. Mary Scott and include questions about why I am at the Emergency Department today, where I usually go for health care, health care services I may have received in the last year, and reasons that prevent me from getting health care I think I need.

There are no foreseeable risks or discomforts if I agree to participate in this study.

Although there may be no direct benefits to me, the possible benefits of my participation in the interview includes providing information to health care managers who may be planning services for people who live in rural areas.

The results of this interview will be written in a report, but my name or identity will not be revealed and my interview will be grouped and presented with all other interviews. The researcher will do the following to maintain confidentiality of my records: Mary Scott will keep the data labeled by subject codes, not names, in a locked file cabinet in her home office, in which only she has access, for a period of three years after the research is conducted, and at that point in time all of the data will be destroyed with a paper shredder.

I will not be paid for my participation.

Any questions I have concerning the research study or my participation in it, before or after my consent, will be answered by Mary Scott (900 N Roberts Ave, Arcadia Florida 34265, 863-494-8485) or Dr. Mary Beth Zeni, Assistant Professor, Florida State University College of Nursing, 413 Duxbury Hall, Tallahassee, Florida, 32306, (850) 644-5355.

If I have questions about my rights as a volunteer, participant in this research, or if I feel I have been placed at risk, I can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Office of the Vice President for Research, at (850) 644-8633.

I have read the above informed consent form. I understand that I may withdraw my consent and stop participation at any time without penalty or loss of benefits to which I may otherwise be entitled. In signing this consent form, I am not waiving any legal claims, rights or remedies. A copy of this consent form will be given (offered) to me.

Subject's Signature _______________________________ (Date) __________________

Other Signature (if appropriate) _______________________________ (Date) __________________
Consentimiento

Factores Asociados con el Uso No-Urgente de la sala de emergencia

He sido informado que Mary Sott, RN, BSN, ha requerido mi participación en un estudio de investigación como parte de su trabajo estudiantil en el Colegio de Enfermería de la Universidad Estatal de la Florida.

Que el propósito de esta investigación es estudiar las razones por las cuales las personas usan la Sala de Emergencia del hospital local. Esta investigación puede que ayude al hospital a planear los servicios para las personas del área. Serán un total de 50 personas que voluntariamente discutirán las razones por las cuales usan la Sala de Emergencia para el cuidado de salud.

Mi participación constará de una entrevista y tomará alrededor de 20 minutos. La entrevista será llevada a cabo por la Sra. Mary Scott e incluye preguntas acerca de porqué estoy en la Sala de Emergencia en el día de hoy, dónde usualmente yo voy a recibir cuidado de salud, los cuidados de salud que yo recibí el año pasado, y las razones que impiden que yo reciba el cuidado de salud que yo creo necesitar.

No hay riesgos ni molestias previsibles si yo consento a participar en este estudio.

Aunque directamente yo no recibiré ningún beneficio, los posibles beneficios de mi participación en esta entrevista incluye proveerles información a los directores de cuidado de salud los cuales pueden estar planificando servicios para las personas que viven en áreas rurales.

Los resultados de esta entrevista serán escritos en un reporte, pero mi nombre o identidad no será revelada y mi entrevista será agrupada y presentada con las otras entrevistas. El investigador hará lo siguiente para mantener la confidencialidad de los datos; Mary Scott mantendrá los datos clasificados en códigos, no con nombres, en un archivo bajo llave en la oficina de su casa, al cual solo ella tendrá acceso, después que la investigación haya sido conducida se archivarán por un período de tres años, al cabo de los cuales todos los datos serán destruidos en un triturador de papel.

Yo no recibiré ningún pago por mi participación.

Cualquier pregunta que yo tenga concerniente a esta investigación o acerca de mi participación en la misma, antes o después de mi consentimiento, será contestada por Mary Scott, 900 N Robert Ave, Arcadia, Florida, 34265, 863-494-8485 o por la Dra. Mary Beth Zeni, Asistente de Profesor, Colegio de Enfermería de la Universidad Estatal de la Florida, 413 Duxbury Hall, Tallahassee, Florida, 32306, (805) 644-5355.

Si yo tengo preguntas acerca de mis derechos como voluntario, participante en esta investigación, o si yo siento que he sido puesto en algún riesgo, yo puedo ponerme en
contacto con la Cátedra del Comité de Asuntos Humanos, Junta de Revisión Institucional, a través de la Oficina del Vice-Presidentede la Investigación, al (850) 644-8633.

He leído el consentimiento arriba mencionado. Yo entiendo que puedo retirar mi consentimiento y detener mi participación en cualquier momento sin ser penalizado o sin temor a perder los beneficios a los cuales tengo derecho. Al firmar este consentimiento, yo no estoy cediendo ningún reclamo legal, derechos o remedios. Sé me entregará (ofrecerá) una copia de este consentimiento.

Firma del Sujeto________________________(Fecha)_______________________

Otra Firma(si es apropiado)________________(Fecha)_______________________
INTRODUCTION

Thank you for agreeing to talk with me about this research being conducted, I appreciate your time. I am going to ask you a set of questions. The purpose of asking these questions is to find out about your use of medical care the past year. As we discussed during the informed consent process, you will not be identified on the interview form or in any study. Your responses will be added to all other responses and reported as a group. The information you provide may help the hospital in learning about health services needed in the area.

1. Why did you choose the Emergency Department today rather than another health care provider or facility?
   __________________lack of primary care provider
   __________________convenience
   __________________financial reasons
   __________________transportation
   __________________location
   __________________urgency of problem
   __________________new to area
   __________________Don’t know (meaning, cannot provide answer)
   __________________other- record reason given

2. Do you have a personal doctor or nurse practitioner that you see on a regular basis and could call if you had any health concerns?
   ___ Yes (if yes complete number 3)
   ___ No   (if no skip question number 3 and continue to number 4)

3. If yes, to number 2, then ask: How many times in the last 12 months (one year) have you seen your doctor or nurse practitioner? _________

3.a. What were the reasons you saw your doctor/nurse practitioner?
   _____________________________________________________________________
   _____________________________________________________________________

3.b. Did one of these visits include a physical exam? ________Yes ________No
4. If no to number 2, then ask: Since you do not have a personal doctor or nurse practitioner, who do you usually see for your health care?

____________________________________________________________________________

____________________________________________________________________________

4.a. How many times in the past 12 months (1 year) have you received health care?

________ times

For what reasons? (Describe why you sought health care)

____________________________________________________________________________

____________________________________________________________________________

4.b. If it still appears that the interviewee does not have a personal doctor/nurse practitioner, then ask: What do you think prevented you from having a personal doctor or nurse practitioner? (Probe for barriers to access and utilization)

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

5. I am now going to ask you about certain health care services people your age and gender may receive on a yearly basis. Please tell me if you received the following services in the last 12 months (1 year). If you have not received the service, then tell me how many months it has been since you last received the service.

1. Have you had a vision or hearing screening exam in the past 12 months?

______ Yes ______ No

If no, when was the last time you had one and where? Recommended age 50+ annually.)

____________________________________________________________________________

2. Do you wear any corrective lenses? ______ Yes _____ No

If yes, when was your last eye exam and is your prescription current?

____________________________________________________________________________

3. Do you wear any hearing devices? ______ Yes _____ No

If yes, when was your last hearing exam and is your prescription current?
4. Have you had a dental exam in the past 12 months? _____Yes _____No
   If no, when was the last time you had one? (Recommended yearly ages 18+)

5. Have you had a tetanus shot within the past ten years? _____Yes _____No
   If no, have you had one ever as an adult?

6. Have you had a flu (Influenza) immunization within the past 12 months?
   _____Yes _____No
   If no, when was the last time you had one? (Recommended ages 18+ annually.)

7. If older than 65, have you had a pneumonia (pneumococcal) immunization
   within the past five years? _____Yes _____No
   (Recommended for 65+ and more than five years ago or sooner with risk
   factors)

8. Has your stool been checked for blood? _____Yes _____No
   (Recommended yearly ages 50+)

9. Have you had your cholesterol checked within the past year? _____Yes
    _____No
   If no, when was the last time you had it checked? (Recommended every 5 years
   at ages 18+ or sooner with associated risks.)

10. Have you had a physical in the past year? _____Yes _____No
    If no, when was the last one you had?
Men

1. Do you know how to perform a testicular exam? _____Yes _____No
   If so, how often do you perform them? (Recommended yearly ages 18+)

2. Have you ever had a Prostate exam or a blood test drawn for your Prostate function?
   _______Yes _______No
   (Recommended yearly age 50+ or sooner with associated risk factors.)

3. Have you ever had a rectal exam? _______Yes ____No
   (Recommended yearly age 50+)

Women

1. When was your last pap smear or vaginal exam from you gynecologist?
   (Recommended yearly ages 18+)

2. Have you ever had a mammogram? _______Yes _______No
   (Recommended baseline is age 35 and yearly thereafter.)

3. Do you perform self breast exams? _______Yes ____No
   (add - if so, how often)

Closing Questions

1. Are there any health services you have needed in the past 12 months and were not able to obtain?
   ___ yes – if answered yes, then ask 1.a., 1.b., and 1.c.
   ___ No

   1. a. Please describe the care you needed:
1. b. How did you determine if you needed the care? (Probe for health professional referral)

1.c. What were the factors that prevented you from receiving the care you needed?

2. Thank you for your time. Is there anything you would like to add to the interview?
Hoja de Entrevista
Factores Asociados con el Uso No-Urgente de la sala de emergencia
Universidad Estatal de Florida
Colegio de Enfermería
Tesis Postgraduado

Número de Identificación del Cliente________
Fecha de revisión del expediente________
Hora de la revisión del expediente________

INTRODUCCION

Gracias por acceder a hablar conmigo acerca de esta investigación que se está llevando a cabo. Aprecio su tiempo. Voy a hacerle una serie de preguntas. El propósito de estas preguntas es averiguar acerca de su uso de cuidado médico el año pasado. Como se le informó cuando pasamos por el proceso de consentimiento, usted no será identificado en esta entrevista o en ningún estudio. Sus respuestas serán añadidas a todas las demás respuestas y serán reportadas en grupo. La información que usted nos provea puede ayudar al hospital a determinar los servicios de salud que se necesitan en esta área.

1. ¿Por qué usted escogió venir a la Sala de Emergencia en el día de hoy en vez de ir a su doctor o a otra facilidad de salud?
   ________________no tengo un doctor particular
   ________________conveniencia
   ________________razones financieras
   ________________transportación
   ________________ubicación
   ________________urgencia del problema
   ________________nuevo en el área
   ________________No sé (queriendo decir que no puede proveer una respuesta)
   ________________otra- escriba la razón dada

2. ¿Tiene usted un doctor particular o un enfermero especialista al cual usted ve regularmente y al que puede llamar si tiene algún problema médico?
   _______Si (complete el #3 si dice que sí)
   _______No (brinque a la # 4 si dice que no)

3. Si dice que si, a la pregunta #2, entonces pregunte: ¿Cuántas veces en los pasados 12 meses (1 año) ha visto usted a su doctor o enfermero especialista?________

3a. ¿Por qué razón vió usted a su doctor/enfermero especialista?
3b. ¿Alguna de esas visitas incluye un examen físico? Si____ No____

4. Si contesto no a #2, entonces pregunte: ¿Cómo usted no tiene un doctor particular o enfermero especializado, ¿a quién usted ve usualmente para su cuidado médico?

4a. ¿Cuántas veces en los pasado 12 meses (1 año) usted ha recibido cuidado de salud?

_______ qué razones? (Describa porque usted busco cuidado de salud)

4b. Si aún así parece que el entrevistado no tiene un doctor particular/enfermero especializado, entonces pregunte: ¿Cuál cree usted que es la razón por la cual usted no tiene un doctor particular/enfermero especializado? (Indague por barreras al acceso y uso)

5. Ahora voy a preguntarle acerca de ciertos servicios que personas de su edad y sexo reciben anualmente. Por favor, dígame si usted recibió los siguiente servicios en los pasados 12 meses (1 año). Si usted no ha recibido este servicio, entonces dígame cuantos meses han pasado desde la última vez que usted recibió este servicio.

1. ¿Ha tenido usted un examen de la vista o del oído en los pasados 12 meses?

_________Si __________No

Si no, ¿cuando fue la última vez que tuvo uno y dónde? Se recomienda anualmente los 50+ años)

2. ¿Usa usted lentes correctivo?_________Si_________No

Si contesta que sí, ¿cuándo fue su último examen, esta su receta esta al día?

3. ¿Usa usted algún aparato para ayudarle a oír? _______Si_______No
Si contesta que sí, ¿cuando fue su último examen del oído, esta su receta está al día?

4. ¿Ha tenido usted un examen dental en los pasados 12 meses? Si No

Si no, ¿cuando fue la última vez que tuvo uno? (Se recomienda anualmente 18+ años)

5. ¿Ha recibido usted en los últimos 10 años la vacuna en contra del tétano? Si No

Si no, ¿la ha recibido alguna vez siendo un adulto?

6. ¿Ha recibido usted la vacuna en contra de la gripe (influenza) en los pasados 12 meses? Si No

Si no, ¿cuando fue la última vez que la recibió? (Se recomienda anualmente 18+ años)

7. Si es mayor de 65 años, ¿ha recibido usted la vacuna en contra de la neumonia en los pasados 5 años? Si No

(Recomendado para 65+ años y más de 5 años o antes si hay factores de riesgo)

8. ¿Ha sido su escrita chequeada para saber si hay sangre en ella? Si No

(Recomendado anualmente edades 50+)

9. ¿Le han chequed su colesterol en el pasado año? Si No

Si no, ¿cuando fue la última vez que se lo chequearon? (Recomendado cada 5 años a la edad de 18+ o antes si hay riesgos asociados.)

10. ¿Ha tenido un examen físico en el pasado año? Si No

Si no, ¿cuando fue la última vez que tuvo uno?
Hombres

1. ¿Sabe usted como hacerse un examen de los testículos?__________Si__________No________

Si contesta si, ¿cuan a menudo se lo hace?(Recomendado anualmente edades 18+)

2. ¿Ha tenido usted un examen de la próstata o un examen de sangre para revisar las funciones de su próstata?
______________Si______________No

(Recomendado para hombres de 50+ años o antes si hay factores de riesgo)

3. ¿ Ha tenido alguna vez un examen rectal?___________Si_____________No

(Recomendado anualmente edades 50+)

Mujeres

1. ¿Cuando fué su último examen vaginal o Papanicolaou hecho por su ginecólogo?
(Recomendado para las edades 18+)

2. ¿ Se ha hecho alguna vez un mamograma?_________Si_____________No

(Recomendado a los 35 años y anualmente de ahi en adelante)

3. ¿ Se hace usted una autoevaluacion de sus senos?____________Si______________No

(añada- si es asi, ¿cuan a menudo?)

Preguntas finales

1. ¿Hay algún servicio de salud que usted necesita en los pasados 12 meses y que no pudo obtener?
_______Si, si contesta si, entonces pregunte 1.a., 1.b., y 1.c.
1.a. Por favor describa el servicio que necesita:


1.b. ¿Cómo usted determinó que necesitaba cuidado?


1.c. ¿Cúales fueron los factores que le impidieron a usted recibir el cuidado que necesitaba?


2. Gracias por su tiempo. ¿Hay algo que usted quisiera añadir a esta entrevista?


APPENDIX I

CHART ABSTRACTION FORM
Chart Abstraction Form

ID Number __________________

Outpatient/Emergency patient Registration Face Sheet
1. Age: _______________________________________________
2. Sex: _______________________________________________
3. Race: _______________________________________________
4. Ethnicity: ___________________________________________
5. Marital Status: _______________________________________
6. Primary Payer: _______________________________________
7. Secondary Payer: ______________________________________

Emergency Department Nursing Record
1. Triage Code: __________________________________________
2. Chief Complaint: _____________________________________
3. Chronic Conditions: ___________________________________
   ______________________________________________________
   ______________________________________________________
4. Disposition: __________________________________________
5. Other: _______________________________________________

Data Codes

<table>
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APPENDIX J

INSTITUTIONAL PROTOCOL FOR TRIAGE
From: Lori Prescott
Subj: Triage
Date: Thu Dec 15, 2005 2:39 pm

DESEOTO MEMORIAL HOSPITAL
POLICY MANUAL

POLICY NUMBER: ED.054
DEPARTMENT: Emergency Department
SUBJECT: Triage of Patients Seeking Medical Care
EFFECTIVE DATE: 5/30/94
REVIEWED: 2/98; 8/98; 9/99; 1/00; 3/01; 5/04
REVIEWED: 12/05

I. PURPOSE

To provide an organized system of reception and prioritization of patients to ensure that timely and appropriate attention is afforded the seriously ill or injured patients. To create a positive image to patients, their families, and the community. Decrease the waiting period; thus, increasing patient satisfaction through expeditious processing of patients by triage personnel.

II. POLICY

An Emergency Department RN, LPN, or ER Tech will be assigned to triage patients for the Emergency Department and facilitate communication between those in the waiting room and patients in the treatment area. The emergency department RN, LPN, or ER Tech works under the direction of the Emergency Department Nurse Manager in her absence under the direction of the Emergency Department Charge R.N. on duty. Competency will be established and each individual will complete prior to being assigned triage.

The person’s presenting complaint will be evaluated by the triage personnel upon arrival and priority of treatment shall be established.

Patients with an acuity level of Priority Emergency, will be immediately taken to Emergency Department treatment area.

All stable ambulatory and W/C ambulance patients will be assessed by triage personnel. The Emergency Department will determine patient acuity level by using the following classification system:

PRIORITY I-EMERGENCY:
Patient requires immediate evaluation and treatment for a life threatening problem.

Disposition: The triage nurse will bring patient directly to treatment area and give report to primary nurse.

PRIORITY II-URGENT:
Patient needs prompt medical attention and should receive medical treatment as soon as physician and bed are available. Should patient's condition worsen, then classification will be changed to emergent by triage personnel. The patient will be re-evaluated by Triage Nurse if wait is greater than one (1) hour and will be documented on nursing record.

Disposition: Patient will be directed to receptionist for completion of ED record or taken to treatment area. The urgent patient will be seen as soon as treatment area and physician are available. The patient will be instructed to return to triage nurse if condition worsens.

PRIORITY III - NON-URGENT:
Patient needs evaluation and treatment, but time is not critical. Patient must be re-evaluated by triage personnel if delay is greater than two (2) hours and re-evaluation must be documented on nursing record.

Disposition: Patient will be directed to receptionist for completion of ED record. The non-urgent patient will be seen as soon as treatment area and physician are available.

General appearance, vital signs and subjective patient history must be considered when determining priority rating.

See attachment: Guidelines Indicating Treatment Priorities for Triage: Adult & Pediatric.

III. PROCEDURE

a. Greets patients/families as they arrive. Assist patients in and out of vehicle.

b. After triage is completed, direct patient/family to registration desk. Give emergency department registration nursing record to be placed with chart.

c. Initiate nursing record and include the following:
   (1) Time, mode of arrival, triage code.
   (2) Allergies, weight, tetanus history, immunizations, LMP.
   (3) Pre-hospital care, past medical history, current medications.
   (4) Chief complaint, obtain vital signs.
   (5) Pain assessment scale
   (6) History of TB exposure. Pediatric nursing record is to be used on all patients between the ages newborn up to 16 years of age.

d. Obtain information regarding patients in the treatment area and relay it to those who are waiting in the waiting room as requested.

e. Inform waiting patients of delays. Encourage reasonable expectations for care. Answer questions and provide explanations as appropriate.

f. Reassess waiting patients at least hourly to determine the
stability of condition and document findings.

g. Maintain constant awareness of patient flow in the emergency department treatment area in order to facilitate patient care.

h. Communicate with Emergency Department nursing staff about available patient care rooms.

i. Remain aware of patient flow in waiting room. Assist family members with questions and concerns about patients.

j. Maintain "crowd control" in Emergency Department waiting area.

APPROVED BY:

Unit Manager  Vice President of Nursing
REFERENCES


Premier Services: Eisenhower Medical Center. (n.d.) Retrieved April 11, 2006 from [http://www.emc.org/body.cfm?id=14](http://www.emc.org/body.cfm?id=14)


BIOGRAPHICAL SKETCH

Mary Scott graduated from South Florida Community College in 1996 with her degree in Nursing. Her practice in nursing started in 1990 as a licensed Practical Nurse and she began working in the Emergency department in 1994. She has had many hours practicing in cardiology as well. Mary has worked in a cardiologist office as well as in a cardiac catheterization lab scrubbing into interventional procedures.

Mary graduated from Florida State University in 2004 with her BSN and plans to graduate this spring of 2007 with her MSN. She plans to practice as a family nurse practitioner in Southwest Florida.