

CHARACTERISTICS OF PATIENTS CHOOSING EMERGENCY DEPARTMENT
(ED) OVER PRIMARY CARE

BY

JAMES OSTRANDER BS, BSN, RN

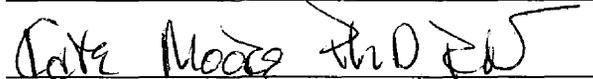
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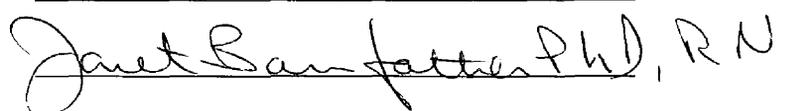
Committee Chairperson:

Kate Moore PhD, RN



Committee Member:

Janet Barnfather PhD, RN



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ABSTRACT

The purpose of this study was to conduct a pilot study examining the Basic Needs, according to Maslow's theory and operationalized with the Basic Need Satisfaction Inventory (BNSI), of patients with a family practitioner and medical insurance that visited the ED with a non-emergent condition and comparing BNSI total score based on phoning status. The BNSI was administered to subjects (N=21), 57% women (n=12) and 43% men (n=9), in a Midwestern Level II Trauma Center who presented during the data collection period with medical insurance, a family practitioner, and a non-emergent condition. BNSI total score on basis of phoning status was compare with a Mann-Whitney U=38.5 (p=.62). Fisher's Exact Test comparing Gender and Phoning status was = .167 (p=.68). Age, pain scale, and BNSI total score were examined for relationships between variables with Person's correlation. The small sample size may have contributed to the non-significant findings. This operational definition of "non-emergent" yielded such a small sample size, and might suggest that the "abuse" of the ED with non-urgent conditions reported in the literature may not be as large as suspected.

CHAPTER I

INTRODUCTION

U.S. emergency department visits soared to 102.8 million in 1999, up 14.5 percent from 1990 (Haugh, 2001). Criticisms of long waits, untimely care, and a tendency to concentrate on acutely ill patients are characteristic of most large university hospital emergency departments (Covington, Erwin, & Sellers, 1992). As health care becomes more competitive ED managers cannot afford the resultant poor public relations (Covington et al., 1992). As its name indicates, the hospital emergency department (ED) was originally created to provide immediate care for patients with life-threatening medical conditions, trauma, or injuries, and not to treat minor illnesses or provide primary care. The term “emergency” continues to be difficult for health care policy makers to define, difficult for emergency care givers to describe, and difficult for a large segment of the patient population to comprehend. EDs are currently overutilized, creating a pattern of costly and inefficient health care delivery (Glick & Thompson, 1997). Patient utilization of emergency care is increasingly dependent on both patient urgency and patient perception of access to viable health care alternatives (Hunt, DeHart, Allison, & Whitley, 1996). Non-emergent cases presenting in the ED have been characterized as “inappropriate”, “misuse”, or “abuse” of the health care system. Guttman, Nelson, and Zimmerman (2001) recognized a negative overtone with ED staff who, when presented with a question about non-emergent visits by pediatric patients, described patient complaints as “trivial and annoying”.

One attempt to control the problem of overcrowding ED is the institution of an Urgent Care Center (UCC). Merritt, Naamon, and Morris (2000) found that there was a highly significant (48%) drop in ED visits in the adult population after opening a UCC. Opening the UCC decreased strain on the ED and staff resources, allowing precious resources to be used for the more severely ill. This is especially important to nursing, because nurse practitioners (NPs) have been shown to be cost effective in staffing the UCC. This places the NP directly in contact with the non-emergent patients, and offers a tremendous opportunity for education. Even as cost effective as NPs can be in the UCC, UCCs are still more costly than a primary care office visit. Baker and Baker (1994) estimate that ED use for non-emergent care costs two to three times as much as the cost of comparable care in clinics or other non-emergent care settings. In a 1992 study conducted by the U.S. Department of Health and Human Services' Office of the Inspector General, average ED charges for treating non-emergent conditions were from 1 to 5 times that of a Medicaid-covered visit to a physician's office (Martin, 2000). According to the 'Restrictive Provider' ideology, a provider should aim to make parents or guardians more self-conscious about their current visits and to direct them in the future toward using primary care sites for non-emergent conditions (Guttman et al., 2001).

In conclusion, ERs are over crowded with increasing acuity of patients and it is important to relieve some of the added stress and misallocation of vital resources placed on the ED by non-emergent conditions

CHAPTER II

REVIEW OF LITERATURE

Several studies have evaluated appropriateness of emergency department visits. Thompson and Glick (1999) studied appropriateness and grouped non-emergent conditions to include superficial injuries, uncomplicated fractures, pharyngitis, upper respiratory tract infections, gastroenteritis, skin disorders, head and backaches, and miscellaneous symptoms such as conjunctivitis, earwax, hiccoughs, and heartburn. Lowe and Bindman (1997), in contrast, argued that there is inconsistency when trying to determine appropriateness of an ER visit. Lowe and Bindman (1997) went as far as to question proposals to decrease ED utilization through gate keeping systems that require telephone authorization from a primary care physician. This is very much in contrast to Kelly (1994), who demonstrated referral of patients by triage nurses out of the ED to primary care settings had decreased non-emergency care treatments in the ED. Hunt, DeHart, Allison, and Whitley (1996) studied the difference between appropriateness according to the medical community and appropriateness according to the patient, they found that a majority of the time the physician and patient were in agreement as to the severity of the illness. This is in great contrast to other studies about the consensus of the ED staff and patients (Guttman et al., 2001).

A number of studies have examined patients on public aid or uninsured and described their use of ED for non-emergent purposes. Bond, Stearns, and Peters (1999) investigated the relationship between non-emergent and urgent visits in a population of insured and public aid or uninsured patients who chronically use an ED, and found a high

rate of inappropriate ED use by uninsured/public aid patients. These findings were consistent with several other studies. Misuse of the ED for non-emergent illnesses is not restricted to the uninsured population. Surprisingly, Bond, Stearns, and Peters (1999) also found that insured patients made up nearly half (42.6%) of non-emergent visits to the ED. Additionally, the highest frequency of visits occurred between 8:00 AM and 4:00 PM, when most alternative non-emergency facilities are open. Visits not requiring the resources of an emergency facility can be handled more efficiently and at a reduced cost by primary care centers (Glick & Thompson, 1997). In contrast, Hunt, DeHart, Allison, and Whitley (1996), found that utilization of the ED by most patients appears to be more appropriate when taking into consideration the patient's prospective perceptions of pathology and the range of viable primary care alternatives. Piehl, Clemens, and Joines (2000) found a relationship between decreased visits to the ED and increased access to primary care services.

The indigent population is frequently reported as one of the major consumers of misallocated resources in the ED, but not the only consumers. This problem also encompasses those patients who have a family practitioner and medical insurance.

Theoretical Framework

Maslow (1987) argues that all human needs can be arranged in a hierarchy, beginning with physical needs at the base – for air, food, and water. Next come four levels of psychological needs – for safety, love, esteem, and culminating with self-actualization (Figure 1). If all needs are unsatisfied, and the organism is then dominated by the physiological needs, psychological needs may become simply nonexistent or be pushed into the background (Maslow, 1987).

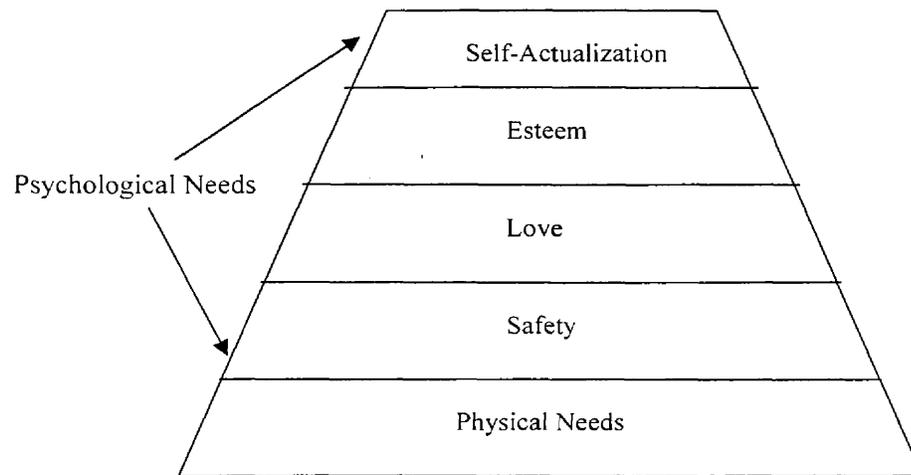


Figure 1: Maslow's hierarchy of needs as interpreted from Maslow (1970)

According to Maslow (1968, 1970a, 1970b) (as cited in Leidy, 1994), the existence of unmet needs and the desire to achieve optimum self-potential are fundamental sources of human motivation. According to Maslow's hierarchy of needs, when needs are not satisfied individuals may feel sickness, irritation, pain, discomfort, etc. These manifestations of unmet needs motivate persons to alleviate them as soon as possible to establish homeostasis. Pain is a factor listed as influencing overuse of the ED (Bond et al., 1999). Maslow's meeting needs hierarchy is not always operationalized in a fixed order. There may be some exceptions to the rules where a "higher" psychological need is placed in front of a "lower" psychological need (Maslow, 1987). Once the previously unmet needs are satisfied, individuals think about the next unmet need.

Reding and Scott (1996) point out that EDs offer an accessible and convenient alternate to primary care facilities, with more flexible hours, and a wide range of diagnostic procedures on site, alleviating the need to travel to another facility for lab tests or x-rays. Applying this to Maslow's theory, the ED offers an accessible and convenient resolution to a physiological and/or psychological need deficit.

Maslow offers a theory of motivation and decision making. Motivation is important when examining why some patients choose to phone their primary practitioner prior to visiting the ED with a non-emergent medical condition and some do not.

Research Question

The research question is as follows: Is there a difference in basic need satisfaction between those who phone and those who do not phone their primary care practitioner prior to visiting the ED with a non-emergent condition?

CHAPTER III

METHODS

Design

This is a descriptive, non-experimental, cross-sectional, prospective study that investigated motivation of the non-emergent patient in the emergency room using Maslow's basic needs deficit. This quantitative study compared BNSI total score with phoning status.

Sample

A non-probability convenience sample of men and women 18 years of age and older who presented to the Level II Trauma Center ED within the period of data collection (February 10, 2003 to March 24, 2003) and met the inclusion criteria (Appendix A) were presented with the opportunity to participate in the study. The inclusion criteria required that the subject must have insurance and a primary care provider. As mentioned earlier, the indigent population is recognized in the research for using the ED for non-emergent conditions. This study was restricted to patients with insurance and a primary care provider.

Setting

This study took place in the Fast Track, or urgent care, area of a private Midwestern Hospital's Level II Trauma Center. Any patient, who presented to the ED with a non-emergent condition while the Fast Track was open, was directed to that area; therefore, Fast Track holds a condensed population of non-emergent conditions in the ED. Fast Track hours of operation are 11AM until 11PM seven days a week.

Instruments

Phoning status is defined as the attempt to contact primary care provider before visiting the ED and was measured as self report on a questionnaire.

Pain was measured on a self-report eleven point scale ranging from 0 (no pain) to 10 (the worst pain you could imagine).

As with Leidy (1990), Basic Need satisfaction was operationalized as the extent to which one perceived that basic needs (physical, safety-security, love and belongingness, esteem/self-esteem, and self-actualization) were satisfied, measured by the 27-item Basic Need Satisfaction Inventory (BNSI) (Appendix D). Respondents are asked to rate, on a scale of 1 (terrible) to 7 (delighted) how they feel about various aspects of their lives. Scores ranged from 1 (low satisfaction with Basic Need) to 7 (high satisfaction with Basic Need). Most items for this instrument were derived from the Quality of Life Index (Andrews & Whithey, 1974), selected to form subscales analogous to Maslow's theoretical description of the basic need categories. BNSI subscales included: physical, safety, love, self-esteem, and self-actualization. The measure has shown evidence of construct validity. It has shown internal consistency reliability in previous studies of health elderly and older adults with COPD of .90 (Leidy, 1990), .91 (Leidy, 1994), and .92 (Leidy & Traver, 1995). Cronbach's alpha of 0.94 has also been achieved in adults under stress (Irvin & Acton, 1996).

Procedure

Patients who signed into the ED were triaged and taken to a room according to standard practice. To increase internal validity, two clinicians were trained in the procedures. This allowed each clinician to give every subject the same information and

attempts to decrease threat of novelty effect. Subjects that had questions about the questionnaire were instructed to fill out the questionnaire as completely and accurately as possible; therefore, no special instructions were given to the subjects decreasing experimenter effects. The clinician then went to see the patient. Once the clinician had determined that the subjects had met the inclusion criteria, the introduction paragraph (Appendix B) was read to the subject. Once the subject agreed to participate in the study and signed the consent form (Appendix C), each subject was given a questionnaire (Appendix D), which took approximately 10 minutes to complete. The subject filled out the questionnaire while waiting for discharge instructions. The conclusion paragraph (Appendix B) was read to the subject by the clinician upon completion of the questionnaire. The Emergency Room nurse collected the completed questionnaires and place them in the collection bin. If the practitioner decided to order a diagnostic test, it would have been difficult to label this visit as inappropriate, regardless of the final diagnosis (Pereira et al., 2001; Sempere-Selva, Peiro, Sendra-Pina, Martinez-Espin, & Lopez-Aguilera, 2001); therefore, any diagnostic test that was subsequently done for the patient during the urgent care visit disqualified the patient from this study.

Plan for Data Analysis

The primary statistical hypothesis, that total scores on the BNSI will differ significantly between populations based on phone in status was tested with the Mann-Whitney U for independent group means of BNSI total score. Subscale constructs were examined for differences between groups using subscale scores for physical, safety, love, self-esteem, and self-actualization. This second portion of the analysis was exploratory and descriptively presented. Power analysis was reported for the sample size obtained.

Gender differences were compared using Fisher's Exact Test, which is better suited for a 2X2 comparison with small sample size. Pearson's correlations describe relationships for Pain scale, Age, BNSI total score (Table 3) and Pain scale, Age, Physical, Safety, Love, Self-esteem, and Self-actualization subscales (Table 4).

CHAPTER IV

RESULTS

To examine basic need satisfaction differences in populations of non-emergent conditions in the ED based on phoning status, twenty-one usable questionnaires were completed. Subjects ranged from 22 to 70 years old with an average age of 36.9 years and SD=12.6 years. There were 57% (n=12) women and 43% (n=9) men (Figure 2). Of the 21 subjects, 29% (n=6) attempted to phone their primary care practitioner and 71% (n=15) did not (Figure 3).

Pain scale ranged from 0 (no pain) to 10 (worst pain you could imagine) with an average of 5.9 out of 10 and SD=2.76.

BNSI ranged from 1.2 to 6.9, with an average of 5.28 (Table 1). The Basic Needs Subscales were found to have similar ranges (Table 1). Power analysis of .05 was achieved with the N=21. Internal reliability was calculated using alpha coefficients for BNSI total score (.98), physical need subscale (.84), safety needs subscale (.91), belonging needs subscale (.87), self-esteem needs subscale (.93), and self-actualization needs subscale (.94).

BNSI total score on basis of phoning status had a Mann Whitney $U=38.5$ ($p=.62$). Mann Whitney U statistic was also calculated for the subscales; physical needs $U=37.5$ ($p=.57$), safety needs $U=43$ ($p=.91$), belonging needs $U=38.5$ ($p=.62$), self-esteem needs $U=34.5$ ($p=.42$), and self-actualization needs $U=40.5$ ($p=.73$). Gender and phoning status were displayed in a 2 X 2 cross tabulation tables (Table 2), and two sided Fisher's Exact

Test = .167 ($p=.68$). Age, pain scale, and BNSI total score were examined for relationships between variables (Table 3), and similar comparisons for basic needs subscales (Table 4).

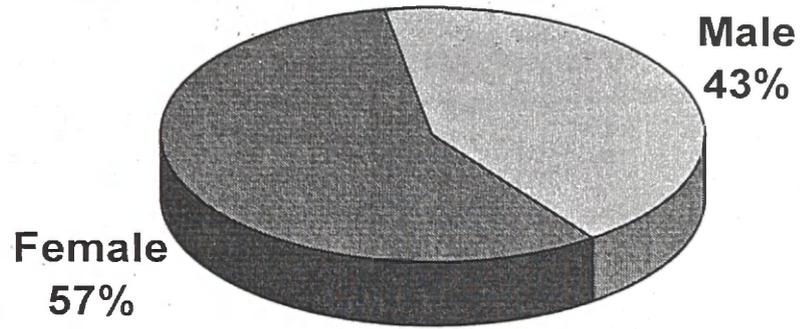


Figure 2: Gender differences of sample

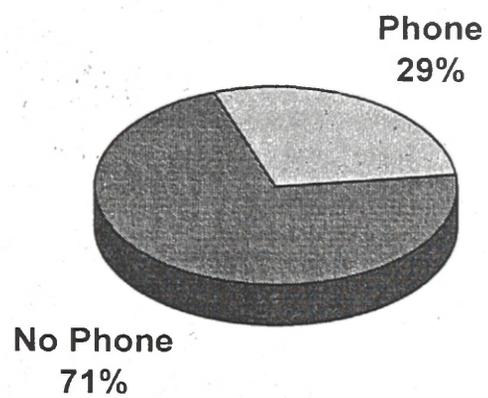


Figure 3: Phoning status differences of sample

Table 1

BNSI Total Score and Subscale Descriptive Statistics

	Mean	SD	Min	Max
BNSI total	5.28	1.17	1.2	6.9
Physical Needs	5.18	1.13	1.2	6.7
Safety Needs	5.10	1.29	1.0	7.0
Belonging Needs	5.60	1.08	2.0	7.0
Self-esteem Needs	5.30	1.29	1.0	7.0
Self-actualization Needs	5.27	1.32	1.0	7.0

Table 2

Cross Tabs of Gender vs. Phoning Status

		Phoning Status	
		Yes	No
Gender	Female	9	3
	Male	6	3

Table 3

Pearson Product Moment Correlations (N=21)

	Age	Pain Scale	BNSI total score
Age		$r = -.262$	$r = -.023$
Pain Scale			$r = .179$
BNSI total score			

Table 4

Pearson Product Moment Correlations (N=21)

	Physical needs	Safety needs	Belonging needs	Self- esteem needs	Self- actualization needs
Age	$r = -.093$	$r = -.049$	$r = .073$	$r = .053$	$r = -.049$
Pain	$r = .121$	$r = .324$	$r = .118$	$r = .135$	$r = .129$

CHAPTER V

DISCUSSION

Using Maslow's theory of hierarchy, we would expect to find a physiological or psychological need in those patients with a primary care provider and insurance who visited the emergency room. Also considering that the ED is often used as a "quick fix", one would expect to find a greater need as measured by Basic Need Satisfaction Inventory in those patients that did not phone their primary care practitioner prior to going to the ED than those patients that did attempt to phone their primary care practitioner. In the population studied, there was no statistical significant difference in mean BNSI score ($p=.62$) of those that did not phone and those that did phone. Similarly, no statistical significance for physical need ($p=.57$), safety needs ($p=.91$), belonging needs ($p=.62$), self-esteem needs ($p=.42$), or self-actualization needs ($p=.73$). Statistical significance was reported based on a 5% chance of $p=.05$; however, with the low power (.05) of this study, statistical significance cannot be considered. A relationship may exist that was not detected due to the small sample size.

Implications for Policy

It is important when discussing policy change for non-emergent conditions in the emergency room to be careful of words such as "inappropriate" or "misuse". Changing the operational definition of non-emergent may yield other results and describe a different population. Thompson and Glick (1999) and Bond, Stearns, and Peters (1999) used different operational definitions of "non-emergent" which yielded much larger

sample sizes. There is only moderate agreement between different methods of determining appropriateness of ED use (O'Brien, Shapiro, Woolard, O'Sullivan, & Stein, 1996).

Alternative Explanations

Sempere-Selva et al. (2001) listed patient preference (and convenience and accessibility) of ED services compared with primary care as a contributing reason for inappropriate use of the ED. It has also been shown that time and lack of outpatient resources to handle acute non-emergent conditions has also contributed to inappropriate ED visits (Anand, Anand, & Ghei, 1976).

Limitations

The small sample size ($n=21$) keeps the power of statistical analysis low (.05). This means there is a 95% chance of a Type II error. The sample size is well below the original intent of 60 subjects, where utilizing significance level (or alpha) or 0.05 and a 95% confidence interval, the power to detect a 5.5% difference as significant is 85%. Small sample size was due partly to the fact that data were collected only during the hours Fast Track was open (11AM-11PM), and not 24 hours/day as originally intended. However, daily length of data collection may have contributed minimally to the low sample size because duration of complaint for less than 24 hours and an arrival between midnight and 8AM was reported as having a possible association with appropriateness of ED visit in some populations (Pereira et al., 2001). Due to the low power of this study, there may be a Type II error, which means that an effect may be present but not able to be detected. With a larger study and increased power, results could then only be generalized

for the population of patients with insurance and primary care practitioner visiting the emergency room with non-emergent conditions during data collection period. With low power (.05) and a 95% chance of a Type II error, the only thing that is safe to say is that more research needs to be done in this area.

Future Recommendations

A larger scale study using the same design and methods, but with an increased sample size is essential to further evaluate any difference in BNSI scores of patients with non-emergent conditions in the ED. Changing the definition of non-emergent may increase the sample size: Bond, Stearns, and Peters (1999) defined non-emergent as a person with a minor injury or health-related complaint, usually ambulatory, needing a physician assessment within 6-8 hours. Additionally, nearly half (285 out of 730) of their non-emergent patients visiting the ED had insurance (Bond et al., 1999). Thompson and Glick (1999) included sprains, strains, or simple fractures in their definition of non-emergent. One way to increase sample size would be to include sprains and strains in the inclusion criteria as Thompson and Glick (1999) and Bond, Stearns, and Peters (1999) did. Another way to increase sample size would be to increase the size of the study and expand to multiple sites at the same time. A third method for increasing sample size would be a longer data collection period. Studies could also compare BNSI between people in the emergency room and those in the family practitioner's office.

CHAPTER VI

CONCLUSION

The purpose of this study was to compare Basic Need Satisfaction for patients presenting to the ED with a non-emergent condition based on phoning status. A descriptive, non-experimental, cross-sectional, prospective study investigated motivation of the non-emergent patient in the emergency room. A non-probability convenience sample of men and women was collected. The setting was the Fast Track area of a private Midwestern Hospital's Level II Trauma Center. Phoning status, Pain, and Basic Need Satisfaction were measured using a questionnaire. This study showed no significant difference of mean BNSI total score between those who did phone and those who did not phone prior to visiting the ED with a non-emergent condition. With the low power (.05), there is a chance that a relationship does exist, but was not found. Because of the high costs of treating non-emergent conditions in the ED, further research is needed to find predictors to identify misusers of resources.

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APPENDIX A

11

List of Inclusion Criteria

- 18 years of age or older
- Have a primary care practitioner
- Present to the Level II Trauma Center on the data collection days
- Able to read and write the English Language
- Alert and Oriented X 3
- Be diagnosed with one of the following diagnoses and will be discharged from the ED
 - Sinusitis
 - Pharyngitis
 - Bronchitis
 - Otitis Media
 - Otitis Externa
 - Upper Respiratory Infection (not other wise specified)
 - Conjunctivitis
 - Hiccoughs
 - Heartburn



APPENDIX B

100

Introduction Paragraph

Hello, my name is (clinician states name). James Ostrander, a University of Michigan Masters of Science in Nursing student, is doing a research study for his Master's in which he is studying people who visit the emergency room with your symptoms. Would you be willing to take a few moments and fill out a questionnaire while you are waiting for your discharge instructions? All information is confidential and your name will not be on the questionnaire or given to anyone. You will not be identified in any report based on this or any other study. Future contact will only result if you select that you would like to receive the results of the study. Not giving consent or withdrawing from this study in no way will affect your treatment here in the emergency department.

Conclusion Paragraph

Thank you for taking time to participate in the study. Results will be completed in May of 2003; if you selected to receive a copy of the results, you should receive them in the mail in summer of 2003.



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APPENDIX C

Consent Form

1. I agree to participate in the research study, “Characteristics of patients choosing Emergency Room (ER) over Primary Care”, that is being conducted by James Ostrander at the University of Michigan-Flint. I understand that this participation involves completing a short questionnaire.
2. I understand that I will be one of approximately 60 subjects involved in this study.
3. I understand that the primary investigator is in no receiving financial gains for me filling out the questionnaire.
4. I have been informed that my participation is voluntary and that I have the right to withdraw my consent at any time. If I do withdraw, my withdrawal will not have any negative effect on my care here in the emergency room.
5. I understand that I can help the success of this project by answering the questions as accurately as possible.
6. I understand that all responses are anonymous and confidential.
7. I understand that I will receive a copy of the consent form.

Signature of subject

Date

Date of Birth

Time of Arrival

If you would like to receive the results of this study please fill in the information below. Results will be available after May 2003. Please contact James Ostrander if you have any questions.

James Ostrander
 University of Michigan – Department of Nursing
 (810) 766-6760

Name:

Address:

City:

State:

Zip Code:



APPENDIX D

Basic Need Satisfaction Inventory

Directions: Each person has his or her own way of viewing a situation. In order to help nurses and other health care providers better understand your views about various parts of your life, we would like you to answer the following questions. Please include the feelings you have now – taking into account what has happened in the last year and what you expect in the near future. Read each question and answer that question by writing one number on the line to the left. All of your answers will be kept confidential.

— — — — — —

Terrible Unhappy Mostly Dissatisfied Mixed Mostly Satisfied Pleased Delighted

How do you feel about...

- _____ 1. The physical comfort of your home – heat, water, lighting, ventilation
- _____ 2. Your level of physical activity
- _____ 3. Your family life (your wife/husband/or another, your marriage, your children).
- _____ 4. The chance you have to know people with whom you can really feel comfortable
- _____ 5. The extent to which you are developing yourself and broadening your life
- _____ 6. How secure you are from people who might steal or destroy your property.
- _____ 7. The amount of respect you get from others.
- _____ 8. Yourself
- _____ 9. The way you handle the problems that come up in your life.
- _____ 10. How much you are accepted and included by others.
- _____ 11. The way other people treat you.
- _____ 12. Close adult relatives – people like parents, in-laws, brothers, and sisters.
- _____ 13. The chance you have to enjoy pleasant or beautiful things.
- _____ 14. The reliability of the people you depend on.
- _____ 15. Your safety.
- _____ 16. How creative you are.
- _____ 17. The amount of friendship and love in your life.
- _____ 18. Your sex life.
- _____ 19. Your own health and physical condition.
- _____ 20. The amount of fun and enjoyment you have.
- _____ 21. The sleep you get.
- _____ 22. How secure you are financially.
- _____ 23. How dependable and responsible people around you are.
- _____ 24. The extent to which your world seems consistent and understandable.
- _____ 25. The extent to which your physical needs are met.
- _____ 26. The way you spend your spare time, your non-working activities
- _____ 27. Your life as a whole.

You are almost finished; there are only a few more questions.

Please circle your answer to the following questions.

Do you have a primary care practitioner? YES NO

Did you attempt to contact your family doctor prior to coming to the emergency room?

YES

NO

On a scale of 0 – 10, 0 is no pain, 10 is the worst pain you could ever imagine, rate your pain at the time you got to the emergency room.

0

1

2

3

4

5

6

7

8

9

10

Sex: MALE FEMALE

What is your current Age? _____

Thank you for taking time to complete the questionnaire. We really appreciate your time and participation

APPENDIX E

REGIONAL MEDICAL CENTER

February 3, 2003

James Ostrander, RN
[REDACTED]

Emergency Department
[REDACTED]

Dear Mr. Ostrander:

The Institutional Review Board met in full board review on December 20, 2002 and approved the following protocol:

- Characteristics of Patients Choosing ER Over Primary Care

Additionally, the informed consent was reviewed and approved at the same meeting with the following addendum: 1) space is provided in the form for the name and phone number of a contact person for patient rights related questions; 2) states the approximate number of patients involved in the study; 3) states whether there are financial incentives, inducements or reimbursements to the primary investigator; 4) space is provided for the in the form for documentation of the participates birth date; 5) states patients will receive copy of the informed consent. It was also stated there are some additions to be made to the protocol as recommended from the Research Advisory Board which are forthcoming.

An annual summary is required. Enclosed is the IRB Application for Continuing Review of Non-Therapeutic Research to assist in compiling the data required by the Institutional Review Board for the annual summary. A reminder letter will be sent to you in approximately one year reminding you of the requirement of the annual summary.

If you have any questions, please contact the Research Department at [REDACTED].

Respectfully,



Harland Verrill, Ph.D.
Chairman, Institutional Review Board

HV/lm

APPENDIX F

THE UNIVERSITY OF MICHIGAN – FLINT

November 19, 2002

To: Kate Moore

From: Suzanne Selig, Chair, Human Subjects Committee



Re: Characteristics of patients choosing Emergency Room (ER) over Primary Care
(Approval #22/02)

This is to inform you that your proposal “Characteristics of patients choosing Emergency Room (ER) over Primary Care” has been approved by the Human Subjects Committee. Please take note that your use of human subjects is approved, only as detailed in your approved application. Should you wish to make any changes in the use of human subjects which differ from the approved proposal, you must inform this committee prior to making these changes. If you are seeking funding for this proposal, it is your responsibility to ensure that your proposed use of human subjects in your funding application is consistent with that approved by this memo.

Should you observe any negative change in the health or behavior of a human subject attributable to this research, you are required to suspend your project. If this happens, please inform the committee as soon as possible for our further review and decision as to the continuation /termination of your project.

This approval for your project is valid for a period of twelve months. If your project extends beyond this period (twelve months), please re-submit your proposal for reconsideration.



APPENDIX G

110

July 9, 2002

James Ostrander
2701 Thomas Street
Flint, MI 48504

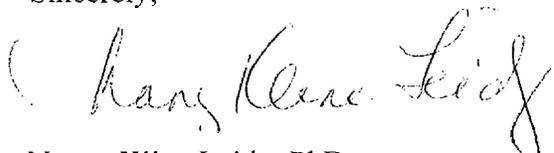
RE: Basic Need Satisfaction Inventory

Dear James:

Thank you for your interest in the Basic Need Satisfaction Inventory. I have enclosed a copy of the instrument and you have my permission to use it in your research on the basic need satisfaction differences of people who do and do not call their primary care physicians before presenting with non-emergent conditions in the emergency department.

Thanks again for your interest, and please let me know if I can be of any further assistance.

Sincerely,

A handwritten signature in cursive script that reads "Nancy Kline Leidy". The signature is written in dark ink and is positioned to the right of the typed name.

Nancy Kline Leidy, PhD
Global Scientific Director

NKL:mao

Enclosure

Dr. Kline Leidy can be contacted at MEDTAP International
7101 Wisconsin Avenue
Suite 600
Bethesda, MD 20814
Phone 301-654-9729