

AN ABSTRACT OF THE THESIS OF

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presented on November 20, 1998. Title: The Emergency Department as a Provider of

Nonemergent Care.

Redacted for Privacy

Abstract approved: _____

Emergency departments (ED) provide access to care for large numbers of patients who have nonemergent medical needs. More than half of the patients presenting to the ED at Salem Hospital in Salem, Oregon, were found to be seeking care for nonemergent medical needs. In an effort to provide an alternative location for receiving this medical care, the hospital opened an Urgent Care Center (UCC) a few blocks from the ED. The purpose of this study was to determine who uses the ED, why, and what effect the UCC had on providing an alternative to the ED. My anthropological methodology uses both quantitative and qualitative techniques. Included in the study is a random retrospective chart review of 462 patients who utilized the ED and 183 patients who utilized the UCC. The collected data were analyzed and compared with information found in the literature review. Interviews with hospital staff and patients using the two facilities are integrated into the analysis. My own experience as a nurse allows me a certain insider's perspective which was useful in interpreting data, while doing observation, and during the interview process.

Findings from my research show that the Urgent Care Clinic does provide an alternative source of health care to the ED for many people. This is particularly true for those whose usual source of care is unavailable and for those who are unable to find a primary care provider to accept them. The emergency department provides nonemergent care for large numbers of patients, some of whom have psycho-social problems which differ as compared to the general population. Some of these patients have moderate psychiatric dysfunction and/or addiction problems or homelessness as well as underlying medical problems, all of which are barriers to obtaining care in a regular office setting. In some cases, the emergency department provides the best option of available care.

The Emergency Department As A Provider Of
Nonemergent Care

by

Catherine M. Stiles

A THESIS

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Masters of Arts

Presented November 20, 1998
Commencement June 1999

Master of Arts thesis of Catherine M. Stiles presented on November 20, 1998

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ACKNOWLEDGMENTS

I wish to express my sincere appreciation to my committee members. In particular I would like to thank Dr. Nancy Rosenberger and Dr. Roberta Hall for their time, encouragement and constructive advice given to me during all phases of the study.

My sincere gratitude also goes to Salem Hospital for their approval and assistance in the collection of data for this project. My thanks to all the staff and patients who participated in this project.

I would also like to thank Dr. Court Smith who always taught that there are at least two sides to every argument and a good researcher will always keep this in mind.

Finally, I would like to thank my family and friends for their support. Special thanks are due to my son and daughter-in-law for their technical support and my husband for his patience.

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THE EMERGENCY DEPARTMENT AS A PROVIDER OF NONEMERGENT CARE

CHAPTER 1

INTRODUCTION

Use of hospital emergency departments (EDs) for nonemergent reasons has been felt to be a problem in the US health care system for several years. It is estimated that approximately one-half of all ED visits in the United States are for nonemergent care in which the patient's condition is not life-threatening or does not require immediate medical attention. It is thought that a large portion of these patients could be cared for more appropriately at the primary health care level. Utilization of the ED for nonemergent health care has raised many questions over the cost of health care provided in the ED, as well as a concern that patients receive only episodic rather than comprehensive health care.

For the twelve month period from June 1, 1994 through May, 1995, the ED at Salem Hospital cared for 64,547 patients. Of these, approximately 38,893 or 60% were seen for nonemergent care (Unpublished Data from Salem Hospital). In February of 1995, Salem Hospital opened an Urgent Care Center to provide an alternative source of health care for those seeking medical attention for minor illnesses and injuries.

In this study I attempted to determine who used the emergency department at Salem Hospital for nonemergent care and why, and what effect the Urgent Care Center had on providing an alternative to the Emergency Department.

Terminology and the Use of Nonemergent in this Study

A number of authors use a variety of reference terms when addressing the population of nonemergency patients in the ED. Terms frequently used to identify this group are those

seeking nonurgent care or those having nonurgent needs. Other sources refer to this population as patients with primary health care needs. Yet others identify them as inappropriate ED users. Because the freestanding clinic owned by Salem Hospital is called The Urgent Care Clinic, referring to my study population's medical needs as nonurgent seemed inappropriate. And, although many of those in my study population could have been appropriately treated in a primary health care setting, it was not within the scope of this study to categorize needs as such. For example, not all primary health care providers suture minor wounds. In an attempt to reduce confusion in identifying my study population I refer to this group as those in need of nonemergent care.

Significance of Study

The health care delivery system in the United States is in the midst of considerable change. The 1990s is a decade which has seen a shift from fee-for-service health plans – or indemnity health insurance plans - to an emphasis on managed care. “A managed care plan can be defined as an integrated delivery system that manages health care services, rather than simply financing or delivering them” (Weiner, 1994:222). Changes in health care management should be expected to decrease emergency room utilization for nonemergent health needs by providing these services at the primary health care level within an office setting. However, the number of people being treated for nonemergent needs within hospital emergency departments remains high and thus is not consistent with this theory.

If changes in the health care delivery system from a fee-for-service to a managed care approach have not significantly changed emergency room utilization, what other factors may influence those seeking services in these facilities? Two suppositions discussed in the literature are that: (1) an inadequate supply of primary care physicians affects ED utilization, and (2), that the ED is used primarily by the indigent. These hypotheses do provide a basic, although limited, view by which to study the population that present to the ED with nonemergent needs. My thesis provides multiple factors by which to look at utilization for those seeking nonemergent care at Salem Hospital.

I am a Registered Nurse who has worked at Salem Hospital for 19 years. Although I have never been a part of the emergency department staff, I have periodically been floated (sent from another area within the hospital) to the ED when there was a need for extra staff. After working in the ED, and caring for patients presenting with nonemergent medical conditions, it became very apparent that there may be many reasons for which a person may utilize this facility instead of obtaining their care in another setting.

The administration and Emergency Department staff at Salem Hospital were very interested in having a sample of specific data collected on patients utilizing the ED and The Urgent Care Clinic. Although the hospital has access to complete data on specific variables such as insurance types, age, gender, etc., they did not have the capability to do comparative analysis on this population which would allow them a broader understanding of utilization. In particular, the senior strategic planner for the hospital was interested in having a sample of ED and Urgent Care Clinic patient profiles. Because the hospital is aggressively planning expansion, my data collection was completed in the sequence which best met the needs of the hospital. Data from this study have been used by Salem Hospital for assessing utilization and for planning future Urgent Care services.

Background and Rationale

In the 1940's, emergency departments - previously known as emergency rooms - were small, poorly equipped rooms used to provide acute care treatment for persons in a medical crisis (Padgett and Brodsky, 1992). By the 1950's, large numbers of ambulatory patients were visiting the hospital EDs for nonemergent use (Padgett and Brodsky, 1992 ; Clark, 1996). Between 1944 and 1970, ED visits increased 312%, compared with only a 50% increase in outpatient visits (Padgett and Brodsky, 1992). In 1966, *The Journal of the American Medical Association* estimated that 42-46% of emergency department visits were nonemergent (Clark, 1996). According to a 1987 National Health Interview Survey, 4% of all doctors' visits were made to emergency departments and 85% of these visits were made for non-life-threatening reasons (Padgett and Brodsky, 1992). The 1992 National Hospital Ambulatory Medical Care Survey found that 55% of ED visits were for nonemergent problems (Gill and

Riley, 1996). In 1992, there were 89.8 million visits to nonfederal emergency departments in the United States, or 35.7 visits per 100 persons (Steinbrook, 1996). In 1993, there were 97.4 million visits to U.S. emergency departments, and, of these, it is estimated that 30-55 percent of the patients could have been cared for in doctors' offices or clinics (Clark, 1996). (This represents between 29.2 million and 53.6 million nonemergent visits.)

Federal and State Involvement

Various levels of legislation have affected health care services and utilization. One reason for government involvement in health care policy reflects its commitment to public health and safety. Another reason for actively participating in health care regulation is that government sources of health care payment represent approximately 45.1 percent of the dollars spent annually for health care in the United States (Sultz and Young, 1997).

Anti-Dumping Laws and their Effects on the Emergency Department

By the 1980s, many emergency departments - particularly in big city public hospitals - became dumping grounds for the indigent and uninsured patients whom private hospitals were declining to treat (Clark, 1996). In March 1986, as part of a budget bill called the Consolidated Omnibus Budget Reconciliation Act (COBRA), Congress passed the Emergency Medical Treatment and Labor Act (Frew et al., 1988).

COBRA requires all emergency rooms that receive Medicare and Medicaid funds to examine all patients who present to the ED and to provide all medical care necessary for stabilization, regardless of the patients' ability to pay. This screening examination can be completed by individuals determined qualified by hospital bylaws and who meet Federal requirements (Derlet and Nishio, 1990). Federal law does not require treatment to be rendered unless the patient has been determined to have an emergency condition by a screening examination.

Emergency medicine practitioners are the only medical specialists required by federal and state law to see and screen all patients who present themselves for care. Failure to comply with COBRA has a direct economic impact because both the hospital and the physician can be fined for failure to comply with the law. Physicians can be fined \$25,000 and hospitals \$50,000 for each violation (Clark, 1996; Frew et al., 1988). In addition, the hospital can be suspended or terminated from the Medicare program (Frew et al., 1988). Additional motivation for physician and hospital compliance is the potential for any person injured by a violation of COBRA to sue the hospital for the injury.

Government as a Source of Health Care Payment

Medicare and Medicaid are the predominant sources of payment for hospital services. Of the \$364.5 billion estimated expenditures for hospital care in 1994, Medicare comprised 29.9 percent, Medicaid, 13.4 percent, private insurance, 35.2 percent, and other sources, 21.5 percent (Sultz and Young, 1997).

Many government programs are overlapping in their intent. For example, Medicaid programs are conglomerates of federal and state source funds with policymaking subject to federal, state, and local administrative and legislative influences. Medicaid costs are the fastest growing component of state budgets (Sultz and Young, 1997). In response to this trend, numerous states are seeking or have obtained waivers from the federal government to either mandate or encourage Medicaid client enrollment in managed care plans in an effort to contain costs (Department of Health and Human Services Office of Inspector General, 1992a; Sparer, 1996; Sultz and Young, 1997).

The Oregon Health Plan and Cost Containment Through Managed Care

On February 1, 1994, Phase 1 of The Oregon Health Plan (OHP) was implemented. This phase of the OHP was designed to both increase eligibility for the thousands of low-income people below the federal poverty level who had not previously qualified for Medicaid benefits, while decreasing the overall cost of health care services primarily through the use of managed care. The writers of State legislation have focused much attention on

the provision of health insurance for Oregonians, particularly the under-served population, with the aim of improving access to primary health care providers.

CHAPTER 2

LITERATURE REVIEW

It has been consistently shown that a large portion of those that use the Emergency Department have needs which are nonemergent. This use is independent of the structure of the health care system. Thus, whether the health care is socialized (such as the Swedish, Canadian, and the Israeli systems), or private (such as the U.S. system), approximately half of ED users present to the ED with nonemergent conditions (Andren and Rosenqvist, 1985; Anson et al., 1991; Brown and Goel, 1994; Burnett and Grover, 1996). Two studies from Canada suggest that ED use has greatly increased since the introduction of universal health care despite the availability of fully insured alternative health care providers, many of which do not require an appointment (Burnett and Grover, 1996; Brown and Goel, 1994).

The Emergency Department Provides Care Which Is Neither Cost Effective Nor Appropriate

Routine use of the Emergency Department for nonemergent care has been criticized because of its role in increasing health care costs and promoting poor overall quality of care resulting from a lack of care continuity (Dept. of Health and Human Services, 1992a and 1992b; Glotzer et al., 1991; Haddy et al., 1987; Halfon et al., 1996). Those who use the ED for nonemergent problems tend to be poor and have symptoms which are often psychosocial in nature, for these problems, the ED can provide care but lacks the coherence in treatment which would benefit this population (Philibert and Beland, 1992). Furthermore, children who use the ED as a regular place of care may not receive routine checkups and preventative care (Mauldon et al., 1994).

Nationwide, enrollment in managed care plans of all types has continued to rise at a steady pace from 37 million members in 1990, to over 100 million today (Sultz and Young, 1997). Managed Care organizations place heavy emphasis on the primary care physicians as "gatekeepers," and primary care providers are viewed as the most influential component in

ensuring that patient care is appropriate to the need, is timely, and coordinated. By requiring specialty health care to be authorized by the primary care physician, managed care organizations seek to avoid the use of high-cost services, including the ED, for complaints that can be treated effectively at the primary level (Silverstein, 1997; Sultz and Young, 1997). Pre-authorization for referrals by the primary physician is thought to ensure coordination and avoid duplication of these services when they are needed.

While supporters of primary health care and managed care groups criticize the quality of care provided ED patients because of a lack of continuity in care, not all ED practitioners agree with this perception. A few studies which compare outcomes of intermittent care with continuous care suggest mixed results (Clark, 96). There is also concern that there are serious risks associated with the rapid expansion of Medicaid managed care in that most health maintenance organizations (HMOs) have little experience caring for the poor (Sparer, 96). Capitated payment systems contain incentives to underserve this population, possibly denying them access to needed medical care, including the ED. According to Mauldon et al (1994), HMOs may not provide an ideal alternative for Medicaid patients since studies suggest that low-income patients may not do as well in this type of system as middle-income enrollees, especially those with preexisting health problems.

Health care in the United States is a big business that consumes over 14 percent of the United States' gross domestic product and is expected to soon exceed \$1 trillion annually in costs (Sultz and Young, 1997). Health care systems include thousands of independent medical practices and partnerships, managed care and provider organizations, public and nonprofit institutions such as hospitals and nursing homes, and other specialized care facilities. Although the ED is viewed as an expensive source of health care, emergency department care represents considerably less than 5 percent of annual health care expenditures in the US (Clark, 1996; Steinbrook, 1996). This includes not only emergency treatment but also the provision of nonemergency care.

The costs of services provided by emergency departments for nonemergent care are criticized as being expensive and economically inefficient. Diverting nonemergent visits from emergency departments to primary health care providers is viewed as a way to cut medical costs. Some sources say that care obtained in EDs is two-to-three times as much as

the same care provided elsewhere, costing health-insurance plans an estimated \$5 billion in unnecessary expenses (Clark, 1996; Dept. of Health and Human Services, 1992a; Williams, 1996). Authors who disagree with these cost analyses posit that a simple comparison of private office charges versus those charged by the emergency department provides a very distorted view. They suggest that EDs are high-cost when in fact they are high charge. This is because 60-80% of patients who use these facilities don't pay the full charge while private physicians collect about 85% of all their charges (Clark, 1996). This suggests that the ratio of costs to charges is much closer for private physicians' offices than for emergency departments. They suggest that a more accurate comparison can be made by examining the actual costs of providing services in the two settings. This method of analysis suggests that the average costs of nonemergent ED visits are similar to private physician office charges, \$62 versus \$50, bringing the actual cost savings if these patients were treated outside the ED closer to \$0.5 billion (Clark, 1996; Williams, 1996). These authors suggest that because the ED has fixed costs, they might as well be utilized fully.

Medical Services Utilization Models

Multiple studies of ED utilization have been conducted. Authors argue that the increasing use of the ED for nonemergent needs may be due to both the convenience and the accessibility of the ED. Convenience and accessibility are powerful incentives which may influence patients' preference of emergency services over primary care providers. EDs provide sophisticated 24 hour a day care, every day of the week, with no appointment necessary. The fact that primary care physicians not only have limited office hours but also have an unwillingness in many instances to accept new patients makes access particularly difficult and ED use more appealing (Andren and Rosenqvist, 1987; Hurly et al., 1989; Padgett and Brodsky, 1992; Shesser et al, 1991; White-Means and Thornton, 1989).

Several studies performed in the US give readers the strong impression that emergency services are often used inappropriately for nonemergent care by low socioeconomic status patients who substitute ED care for care that could and should be provided in another, more cost effective setting (Shesser et al., 1991). However, other studies have found that

socioeconomic status is not the only factor which influences people in the use of the ED for nonemergent care. It is apparent that the decision to present to the ED is complex and its explanation involves the consideration of other factors (Brown and Goel, 1994). Two models found in the literature are useful frameworks with which to look at Emergency Department utilization.

Emergency Services Model

The first model suggests that EDs play three major roles in health care and delivery: (1) they serve as trauma centers; (2) they provide an entrance to the health care system when the usual source of private care is unavailable - for example on weekends and after hours; (3) they serve as a usual source of care for a significant portion of underprivileged users (Buesching et al., 1985; Padgett and Brodsky, 1992; Philibert and Beland, 1992). While not all persons who utilize the ED fit within these three categories, the literature reviewed for this project is consistent with this model of ED use. The role of the ED as a trauma center can be evaluated, in part, by the number of hospital admissions as compared to the overall number of patients evaluated and treated. That the ED is a physician substitute for those whose regular source of care is temporarily unavailable can be evaluated by the number of patients who have been referred to the ED during non business hours. It has been well documented that many of those who use emergency services for nonemergent medical problems tend to be poor and are often receiving public assistance

The Behavioral Model of Access

The second model with which to analyze Emergency Department utilization is the behavioral model of access developed by Aday and Andersen (Aday and Andersen, 1974; Brown and Goel, 1994; Halfon et al., 1996; Padgett and Brodsky, 1992; White-Means and Thorton, 1989). This model of access proposes that the use of health services can be explained as three sets of factors: (1) predisposing factors such as age, gender, family, and other social and cultural characteristics; (2) enabling factors such as insurance coverage, income, and the organizational structure of the health care system; and (3) those factors

which represent the need for health services, such as the presence of chronic or recurrent health conditions and measures of overall health status.

1. Predisposing Factors

It is generally agreed that age and gender are not strong predictors of nonemergency ED utilization. Studies do show that there is a tendency for children under the age of 5 to disproportionately use the ED as compared to older children (Brown and Goel, 1994; Buesching et al., 1985; Melzer-Lange and Lye, 1996; Shaw et al., 1990). This can be rationalized partially in biological terms because the incidence of infectious disease (and resultant parental anxiety) in this age group is high (Brown and Goel, 1994). Most studies do concur that the majority of those who use the ED for nonemergent needs fall into the age category of 17 - 40 (Buesching et al., 1985; Padgett and Brodsky, 1992; White-Means and Thornton, 1989). However, this distribution is unlikely to differ much from that of the general population (Padgett and Brodsky, 1992). There is disagreement among authors on the use of these services by the elderly population. Barnett et al. (1992) argues that the elderly do not use emergency medicine for minor health problems while Brown and Gel (1994) found this group to be significant users.

Although the studies revealed that there are slightly more males than females who utilize the Emergency Department for nonemergent services, this difference was not found to be statistically significant and not a predictor of ED utilization. Injury may account for the slightly higher male utilization rate. The majority of people who show up in hospital EDs are men, with those in their late teens and early 20s especially injury-prone (Associated Press, 1995).

As predisposing factors, family and other social networks have been found to influence Emergency Department utilization. For example, the children of single parent households were found to utilize the ED more frequently than those from two-parent homes (Brown and Goel, 1994; Halfon et al., 1996; Melzer-Lange and Lye, 1996). Living alone and experiencing loneliness also may influence use. It was found that at least half of the adults who used the ED for nonemergent care were not married (Andren and Rosenqvist, 1987; Burnett and Grover, 1996). However, Padgett and Brodsky (92:1192) argue that studies on the influence of social networks and social support on general medical care utilization have

yielded inconsistent findings. They state that "while some studies have linked poor social supports to increases in medical help-seeking behavior, others have noted that helpful social networks may also increase utilization by enhancing access and acceptance of medical care". About his own research findings, Schwartz (95:1023) states "Surprisingly, I found that married individuals (i.e., those with high social support) came to the ED more often than single people. One explanation for this may be that there is another person close by validating the need for emergency care."

Cultural factors affect nonemergent ED utilization to varying degrees. According to White-Means and Thornton (1989), age is the only predisposing condition that has similar effects on ED visits by whites and blacks, with those 18 to 34 of age having the highest utilization. He argues, for example, that income, education, employment status, and type of insurance influence utilization by whites but have little effect on utilization by the black population. According to another study, black children had twice the odds of white children of using EDs for routine sick care; however, Hispanic children were no more likely to use EDs than were white children (Halfon et al., 1996).

2. Enabling Factors

Nationally, Medicare covers 11% of the population, Medicaid provides coverage for 8%, and 14% do not have health insurance (Office of Health Policy, 1993). Patients with Medicaid are more likely to have two or more prior emergency room visits compared with a group of patients with private insurance and those who are uninsured (Davidson et al., 1994; White-Mean and Thornton, 1989). Studies also show that 61% of all ED visits by Medicaid recipients were deemed "inappropriate" in that they could have been seen in another setting, compared with 33% of all ED visits by private insurance and 13% of all Medicare (Alteriis and Fanning, 1991; Dept. of Health and Human Services, 1992a). Although ED utilization rates for the uninsured may be lower than those with a source of insurance, it is of great concern that those who are uninsured reported fewer physician visits and hospitalizations than insured persons, despite suffering from higher rates of ill health (Blendon, 1988; White-Mean and Thornton, 1989).

Low socioeconomic status combined with non-availability of primary care providers appear to underlie much of the ED use in this country (Halfon et al., 1996). Children

residing in counties where the supply of primary care providers was in the top quintile had half the odds of reporting EDs as usual sources of sick care when compared with children in those areas with lower physician-to-population ratios (Halfon et al., 1996). Provider reimbursement levels under Medicaid are low and often limit access. Payments for physician office visits may be less than half the amount paid by Medicare and private insurance (Braveman et al., 1988; Mauldon et al., 1994; Sparer, 1996; Thorpe et al., 1989). A substantial number of office-based primary care physicians do not see Medicaid recipients or specifically limit the size of their Medicaid practices when there is a lack of office-based physicians (Alteris and Fanning, 1991). The effect of primary care physician supply is consistent with other studies that have demonstrated that availability of primary care services has a significant impact on where families seek care when they are sick (Halfon et al., 1996).

Those who use the emergency room as their usual source of health care have an increased probability that they will continue to utilize the ED for this care (White-Means and Thornton, 1989). Padgett and Brodsky (1992) found that among nonemergent users of the ED, the lack of an alternative source of care was most frequently cited as the reason for using these facilities. Also of importance is that poor individuals are less likely than persons of more substantial means to have a regular source of care (Hurley et al., 1989). Thus, for a variety of institutional and economic reasons, these persons are more likely to use EDs instead of private physicians for their basic medical care.

Adults whose primary source of family income was from a public source, such as welfare, are more likely to present to the ED than those whose primary income was from wages, salaries, or other sources (Brown and Goel, 1994). In contrast, however, the same authors found that unemployed adults were not significantly more likely than employed people to have visited the ED on one or more occasions during the previous 12 months. Another study found that among whites, full-time employment decreases the overall number of medical visits and ED utilization, but that full-time employment does not affect utilization within the black population (White-Means and Thornton, 1989).

Proximity to the ED is an enabling factor that may affect utilization. Hospital emergency departments are often located in areas which may be underserved, such as in inner-city

areas. According to Padgett and Brodsky (1992:1193), "Disentangling the effects of the enabling factors - income, insurance coverage, usual source of care, and proximity - are difficult since they are so interrelated." They suggest that few studies have taken these interrelationships into account. Andren and Rosenqvist (1985) found no correlation between the traveling time from home to hospital and the visiting rates of those who "repeatedly" present to the ED.

3. Need Factors

In a study predicting children's use of physician services in an ambulatory setting, Halfon et al (1996) found that the strongest predictors of routine ED use were predisposing and enabling factors, not factors either related to the presence of specific conditions or to general health status. The authors suggest this may indicate that children with specific medical conditions may be more likely to use primary care services that can appropriately address their additional needs for sick care. Another study found there are no major differences in ED use for minor illness patients from different racial, educational, and economic backgrounds, but that patients who utilize the ED tend to have a low frequency of chronic illness and often have no established health care provider (Shesser et al., 1991).

Need factors that appear most significant in predicting nonemergent use of the ED arise from the presence of psychosocial stressors, including psychiatric co-morbidity and alcohol abuse (Padgett and Brodsky, 1992). These authors also found that repeat and high utilizers of ED services are particularly likely to manifest these problems and to live in social isolation. Other specific indicators of need, such as recurrent health conditions (asthma, tonsillitis, head ache, febrile seizures) were not associated with routine use of EDs for sick care (Halfon et al., 1996). Interestingly, it was found that health perception insignificantly influences the decision to visit the ED (White-Means and Thornton, 1989).

The literature shows that use of the emergency department for nonemergent care relates to family finances, ethnicity, proximity, hours-open and lack of an alternative medical center in which to obtain care. An urgent care or intermediate care service offers some of the same features of the emergency department. One of the purposes of this thesis is to explore the question of whether patients will utilize the Urgent Care Clinic as a substitution for the ED when seeking nonemergent medical attention.

CHAPTER 3

METHODS

The study population for this thesis consists of those who use the Emergency Department and the Urgent Care Clinic at Salem Hospital, in Salem, Oregon, for nonemergent care. Salem Hospital is a nonprofit hospital that is governed by a Board of Directors and is the only hospital in the Salem area. While Salem Hospital is in Marion County, the city of Salem lies in both Marion and Polk Counties. There are two other hospitals located in Marion County; one in Silverton and one in Stayton, and one hospital in Polk County, in Dallas.

Of particular interest is that Salem Hospital has the highest number of emergency department visits in the State. In 1994, Salem Hospital's ED had 66,751 visits while the Silverton Hospital ED saw 7,694 patients, the ED at Valley Community in Dallas saw 6,176 patients, and the ED at Santiam Memorial in Stayton had 5,094 visits. During this same time period, St. Vincent Hospital in Portland had the second highest ED use in the State, having had 44,352 visits (State of Oregon: 1994 Annual Hospital Report).

Subjects and Design

Identifying the Nonemergent Population in the Emergency Department

Many of the patients who utilize the Emergency Department are in need of emergency care. However, according to data presented in this study, at least half of the patients do not arrive with complaints or symptoms which would identify them as needing this type of care. To assure that those with true emergency needs are rapidly identified and rendered care, hospital EDs utilize a triage system. The term triage, meaning "to sort out according to quality," first appeared in the 18th century in connection with the wool trade and was first used in reference to the handling of injured people in the 1930s (Clark, 1996). At Salem Hospital the triage desk is the check-in area for patients who are requesting care in the

Emergency Department. A brief history is taken by a qualified triage staff member who is usually an RN with at least one year of experience working in the ED. After assessing the patient's medical condition, the triage personnel assign a triage number to the patient which identifies their type of medical need according to severity (See Table 1 - Criteria for Triage Categorization). For example, those presenting with life-threatening or potential life-threatening medical needs are taken immediately to the treatment area for medical attention. Those triaged in categories 4-A, 4, and 4-FT (Fast track), are required to go through a screening process where a qualified RN further assesses their medical needs. The screening nurse may offer the patient an alternative treatment plan such as going to Salem Hospital's Urgent Care Clinic or making an appointment with their own physician. However, the hospital does not refuse care to these patients should they request to be seen in the ED.

Fast track is a hospital-based system which treats both acutely and minimally ill patients in a parallel fashion within the ED system. At Salem Hospital, fast track is located on the fourth floor while the Emergency Department is located on the first floor. The working hours at fast track are Monday through Saturday from 2 p.m. to 12:30 a.m. and from 12 p.m. to 12 a.m. on Sundays and holidays. Patients who normally would be given a 4-F triage number but arrive during the hours when fast track is closed are given a triage number of 4.

The majority of patients assigned to fast track have similar medical needs as those who could receive their care at the Urgent Care Clinic. In fact, anticipating that much of the nonemergent care would be delivered at the Urgent Care Clinic, fast track was closed the day the clinic opened. Fast track was closed in February of 1995, but reopened within a few months to accommodate patient needs. Although many patients began utilizing the UCC for nonemergent needs, others presented to the hospital for treatment and chose to obtain their care at the ED even when given the option of obtaining care at the UCC. According to hospital staff, certain patients were eager to go to the UCC when given the option, while other patients were reluctant to obtain care outside the ED. (See Figure 1 - Triage number and Hospital Utilization.)

Table 1 Criteria For Triage Categorization

Type 1 - Critical	The patient's condition is life-threatening; e.g., impending cardiac or respiratory arrest.
Type 2 - Emergent	The patient's condition requires immediate medical attention. The patient appears unstable and/or in acute distress.
Type 3 - Urgent	The patient's condition is potentially of a complex medical or surgical nature. Other factors warranting consideration include the potential for violence, intoxicated patients, and patients unable to cope with their condition.
Type 4-A	The patient's condition needs evaluation and treatment. Time is not a critical factor, but this patient's illness/injury warrants higher priority in the normal sequence of care.
Type 4	The patient's condition is not life-threatening. Time is not a critical factor and the patient can safely wait in the lobby until treated.
Type 4-FT	The patient's condition is minor and needs only limited evaluation and treatment. Time is not a factor and patient's condition will not be compromised by waiting. Patient will be triaged to the ambulatory care area. (Fast track)
Ambulance patients	Patients arriving by ambulance require immediate assessment and placement by an RN. Chief complaint and clinical presentation determines whether the patient is triaged to an acute room, exam room or the triage area.

(Source - Salem Hospital's Policy Manual)

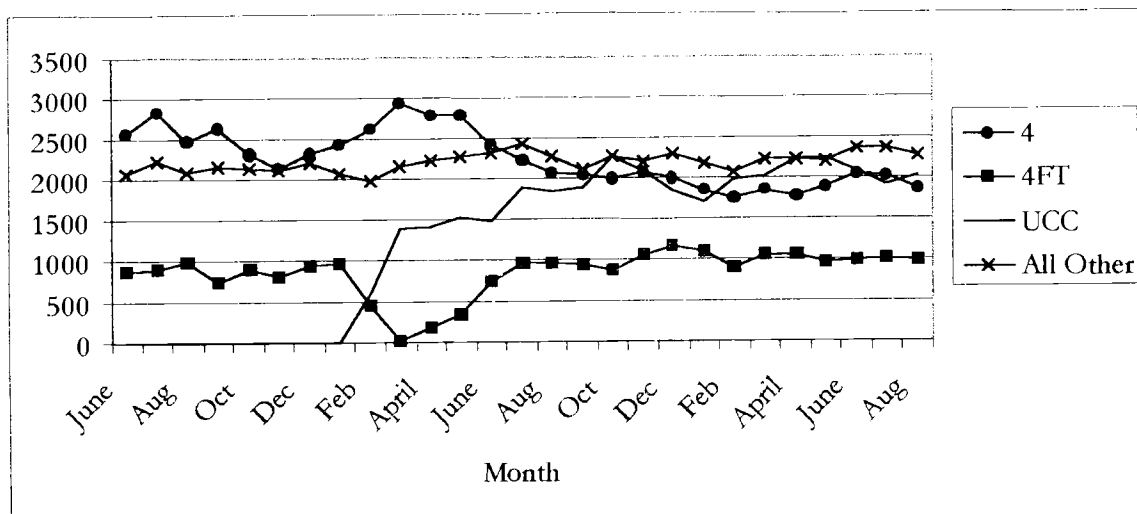


Figure 1 Triage Number and Hospital Utilization June '94 Through August '96 (Source - Unpublished Data from Salem Hospital)

For this study, the patients seeking medical care in the Emergency Department with a triage number of 4 or 4-FT were identified as the ED nonemergent population. Although many of those with a triage number of 4-A could be included in the nonemergent population, there is a potential for some of these patients to have medical needs which may be considered more than nonemergent. To simplify the process of identifying the nonemergent population and to maintain objectivity, the triage categories of 4 and 4-FT were used as the ED nonemergent population.

The Urgent Care Clinic Population

As there is a recognized need for nonemergency episodic care at reasonable cost, urgent care centers have been developed to specifically address the needs and wants of patients to be seen expeditiously (Meislin et al., 1988). These centers provide service to ambulatory patients for whom diagnostic requirements and severity of illness appear minimal, allowing for short treatment time and a lower fee structure.

The Salem area has four such clinics. All provide nonemergency episodic care. All have advertisements in the Yellow Pages of the Salem-Keizer U.S. West Directory stating "No appointment necessary". According to advertisements in the Directory, two of the four

clinics are open Monday through Friday and do not see patients after 7 p.m. A third clinic offers the same basic hours Monday through Friday as well as Saturday from 9 a.m. to 5:30 p.m. and Sunday from 9 a.m. to 4 p.m. Salem Hospital's Urgent Care Clinic is open 10 a.m. to 9 p.m., seven days a week. This clinic is located in the Salem downtown area, two blocks from Salem Hospital. The other clinics are located in Southeast, Northeast, and West Salem.

While the hours are extended to reflect the communities' needs, there is another important difference between Salem Hospital's Urgent Care Clinic and the other clinics. It is my understanding that while the other clinics reserve the right to refuse care based on financial or other considerations, Salem Hospital's Urgent Care Clinic, like the ED, does not refuse care to patients regardless of their ability to pay.

For this study, those seeking medical attention at Salem Hospital's Urgent Care Clinic were also identified as part of the nonemergent population. Occasionally patients do present themselves to the Urgent Care Clinic with needs beyond the scope of care provided at this clinic and are referred to the ED. Although this is only a very small number, those in my sample who were referred will be addressed specifically in the findings section of this study.

Procedure – Data Collection

This is a study that uses both qualitative and quantitative methods of data collection and data analysis. I conducted this study at Salem Hospital. The administration and emergency department staff were actively involved in the study design. Collaboration with staff was necessary to assure that the findings would be informative and useful for both the hospital as well as myself. Data were collected from chart reviews, patient interviews, observation, and from interviews with hospital staff.

Emergency Department and Urgent Care Chart Reviews

For this study two randomized retrospective chart samples were collected. The first was a sample of those who utilized the ED with a triage category of 4 and 4-FT. Seven months of ED charts were available at the time of the sampling. These had been sorted by date and alphabetized by last name for each of the days. The charts represented ED visits for the dates of June 1, 1994, through December 31, 1994. Because the charts were ready for microfilming, care needed to be given to not change their proper sequence. It was also important that the method of random chart sampling be done in such a way that utilization of hospital medical records staff for pulling charts would be minimal. We decided that 14 days of charts would be adequate to obtain both the number and variety for a representative sample. Two days out of each of the seven months were randomly selected so that each day of the week was represented twice in the selection process. Every third qualifying chart was then used for the ED sample population. This produced a sample of 464 patients with an assigned triage number of 4 or 4-FT, two of whom were repeat patients within the sample. The second of the two visits for these patients was then eliminated, resulting in an ED patient sample of 462.

The Urgent Care Clinic opened in February of 1995. In September of 1995 the hospital requested a patient profile sampling of Urgent Care. This chart sample was collected in the same manner as the ED chart sample with the exception that only seven days were included in the sample. These days coincided with the first seven days of the ED sample, for example, the second Tuesday in June or the first Sunday in July. In this manner June, July, August, and the first date in September, all of 1995, became the Urgent Care Clinic chart sample. Through this process, 184 patient charts were reviewed. One patient was a repeat. After eliminating that particular chart the patient sample was 183.

Demographics and medical information were obtained from both the ED and Urgent Care medical charts. Data included age, gender, ethnicity, marital and employment status, area of residence by zip code, insurance type, whether or not they had a personal physician, their medical diagnosis, and the time of day they presented for care. The patient's history and physical were also looked at for pertinent information in addition to the general

diagnosis. For example, documentation of a chronic medical condition, homelessness, or a history of mental illness was noted on the individual patient data sheet.

Using patient identification numbers I was then able to access further information through the medical records computer system. This required the medical records staff to log onto the program for me. For security reasons, only these staff members had the authority to access this program. I was then able to retrieve data on hospital utilization for the chart sample population. This included inpatient and outpatient hospital usage and dates. Using the computer coding system I was able to track the number and dates of ED and Urgent Care visits, hospitalizations, admits to the hospital psychiatric unit, and hospital admissions from the ED. This information was particularly important in identifying those who utilized the ED and UCC more than once during the year. It is important to mention that this particular hospital data program was initiated on June 1st of 1994. Prior patient records, although computerized, provided only dates on which patients used hospital facilities, but did not identify departments where they obtained their care.

Those in the ED sample population were monitored for one year with regards to their inpatient and outpatient hospital utilization. The year ran from June 1, 1994, through May 31, 1995. Those in the Urgent Care sample were monitored for two years. The first year began June 1, 1994, through May 31, 1995, and the second year was from June 1, 1995, through May 31, 1996. Because the Urgent Care Clinic opened in February of 1995, it was of particular interest to observe ED utilization before and after this service was available.

A third means for obtaining information on my chart sample of patients was to use the ED computer in the triage area to look at patients with repeat ED visits. The computers in the ED area have the only access to particular patient information. Here I was able to pull up dates, times, triage category, patients chief complaints, diagnosis, and the history and physical for each of the visits. This information was of importance in tracking ED and UCC utilization of those who used these facilities multiple times during the year. Through this process I was able to look for patterns of individual use. For example, do they present multiple times with the same chief complaint?

Emergency Department and Urgent Care Patient Interviews

Personal interviewing using a predetermined questionnaire was done in the Emergency Department, fast track, and the Urgent Care Clinic waiting areas. Those with a triage number of 4 or 4FT (nonemergent) were the target population. The questionnaire was used as an interview guide to assure that the same questions were asked of each participant. However, these interviews were semistructured in that pertinent information obtained from patients/parents during the interview process, in addition to the structured questions, was collected. (Appendix B - Patient Questionnaire)

The patient interviewing process represents a convenience sample as well as one based on target population availability. I approached patients in the waiting areas only during times of heavy utilization. During these periods patients with nonemergent needs would be waiting for longer periods of time before being seen in the treatment areas. This longer patient wait enabled me sufficient time to approach the person, read my verbal informed consent document (See Appendix A), and complete the questionnaire (See Appendix B). Most interviews required 20 to 30 minutes to complete.

My safety was also a consideration in planning interviews. The ED parking lot is adjacent to a park where drug trafficking and other activities are known to occur. Hospital security requested that I not come into the hospital alone after dark. Initial interviewing, therefore, needed to begin before dusk. Security would then provide me with an escort to my car when I left in the evenings.

Over the 15 month period from August, 1995, through November of 1996, I interviewed 34 patients/parents/guardians in the Urgent Care Clinic waiting area, 12 in the fast track waiting area, and 12 in the Emergency Department waiting room. The 58 interviews represent 62 patients as on three occasions more than one member of the family was being seen. Two interviews were incomplete due to the patient being called to the treatment area prior to completing the interview. The completed portions of these interviews are included in this study.

Although multiple attempts were made over the 15 months to obtain interviews, often the waiting areas were not sufficiently backed up to allow for a 20 to 30 minute interview. Attempts at interviews were made most often during periods when these areas traditionally are busy. In the ED, the treatment areas could be very busy with patients identified with emergent needs, causing long waiting periods for patients identified as having nonemergent needs. However, if there were a lack of emergent patient types, the flow of nonemergent patients into the treatment area could be quite rapid. It is difficult to know how this may have affected the results of the patient questionnaire sample.

During the interview process only three patients refused to participate in the questionnaire. Most patients/parents seemed very positive towards being interviewed and often would wish me luck on completing my "project". One of the interviews began in the ED waiting room where the interview was incomplete when the patient was called to the screening area. The patient was sent from screening to fast track. On the way to fast track the patient stopped and asked me if I wanted to go along to finish the questionnaire. The interview was then completed in the fast track waiting area. Another interview began in the fast track waiting room, continued in the exam room, and was completed in the x-ray waiting area. The parent of the patient (a child) invited me to follow along with them to complete the interview process.

Prior to approaching patients in the waiting areas, I always checked in with staff to let them know I was there. In the ED I would also ask if there were particular patients or families that I should not approach. I did not want to disturb patients who might be distraught or hostile. This was particularly important in the ED waiting room, although patients with specific mental health needs often wait in a separate room next to the triage area. I then would randomly approach people in the waiting area asking if they were waiting to be seen. At times, the ED waiting area would be very crowded with family or friends of patients who were already being seen in the treatment area. These were not selected for interviewing as they did not fit the criteria of being either the patient or parent of a child waiting to be seen. In fast track and Urgent Care I did not find families waiting without the patient. This may have been due to the nonemergent nature of their illness or injury. In the ED waiting area there was a real potential for families to be waiting news of a patient with a critical or emergent condition.

When a patient was approached for an interview, I read the verbal informed consent document. If they agreed to participate the interview was initiated. If the patient was a child or under the age of 18, the parent/guardian was interviewed. One of the participants was 17 years old but insisted that because she was responsible for herself and her two year old daughter, I should interview her. Her interview is included in the findings.

The next person approached for interviewing was selected by the person with whom I had just interviewed. After completing an interview I would ask the interviewee if they noticed who arrived after they had. Each interviewee was able to provide me with this information and then the identified person or group would be approached.

I did attempt to interview the non-English speaking Hispanic population with the questionnaire administered in Spanish. However, this did not prove to be productive as I lacked the proficiency in the language to respond to questions or comments adequately. This only hindered one interview, however, causing both the patient and myself to politely end the interview attempt. All other Hispanic patients/parents that I approached were either bilingual or had a friend or family member in their group who spoke English and translated for us.

After the first 15 interviews (17 patients) the questionnaire was re-evaluated and changes made to better reflect the types of information useful to my study. Two questions from the original questionnaire were deleted and two new questions added. (The questionnaire under Appendix B represents the revised edition.)

The first question deleted from the original questionnaire was "How many people live in your household?" The intent of this question was to gain information about loneliness as a predisposing factor on ED and Urgent Care utilization. However, I found that living alone may answer more questions about economics than loneliness. None of the 15 interviewed lived alone. In fact, many lived in complex extended family living arrangements where the numbers in the household may fluctuate from week to week, often being dependent on who had visitation rights with the children. Two of those interviewed lived in households with nine members and two lived in households with two members. Six living in the household was the most common, with that number given by four of the interviewees. The

remaining seven responses were between nine and two living in the same household. Although the responses were interesting, the question did not provide information on loneliness and ED/UCC utilization.

The second question to be deleted was a two-part question. "Who encouraged you to seek health care for this current problem?" and, "Where does that person most often obtain health care?" The intent of this question was to identify ED/UCC utilization as a learned experience. Are people encouraged to use these facilities by others who use them for nonemergent needs? The question, however, often caused confusion and needed to be rephrased. Eleven of the interviewees stated that they made the decision to seek care for themselves or their child. Two were encouraged by spouse/fiancée to seek care in the ED, one by their mother (who uses a regular physician), and one from a pharmacist. This question was not asked of two interviewees who were unable to complete the questionnaire before being called into the treatment area. The question proved to be time consuming due to the need to rephrase, as well as somewhat less informative than other questions regarding ED/UCC utilization.

Two questions were added to the questionnaire. The first (#13), "How long have you had this particular health plan?" or, if they do not have health insurance, "Have you ever had health care insurance?" After assessing the first 15 questionnaires, it became apparent that the length of time covered by a particular insurance may be important to this research project. Currently, not only are there many new people qualifying for the Oregon Health Plan, but there are many others who lack insurance temporarily due to change in employment, while others may have recently changed insurance coverage from fee-for-service to managed care. The length of time having a particular type of insurance may have an effect on whether people have a regular source of health care.

The second question added to the questionnaire (#20), allowed me the opportunity to have the patient/parent evaluate the seriousness of the illness or injury. The question reads "On a scale of 1-10, with 10 being life threatening and 1 being not very serious, something that would probably get better on its own, where would you rate the seriousness of your/the patient's current health problem? This question provided an array of answers which are be discussed in the findings section.

Observation and Staff Interviews

As mentioned earlier in this paper, particular data about multiple ED/UCC utilization were obtained from computers in the ED area. The computer I most often used was located in the triage area. This afforded me opportunity to spend much time in triage. I was able to observe staff and patients in the triage process, as well as obtain unstructured interviews with staff during "quiet" periods. Often these interviews were centered around particular questions I had while other times conversations were totally ad hoc, covering ideas or concerns brought up by staff. Because the triage staff frequently rotated between triage and the treatment area, this gave me the opportunity to speak to many different staff members.

After completing the chart reviews, the information was entered into a Microsoft Excel worksheet. This enabled me to do basic data analysis on each population as well as comparing data between those utilizing the ED for nonemergent care with those utilizing the UCC. Basic demographics from the questionnaires were entered in a similar fashion.

CHAPTER 4

FINDINGS

The focus of this study is to determine who uses the emergency department at Salem Hospital for nonemergent care, why they utilize this facility, and what effect the Urgent Care Clinic has had on providing an alternative to utilizing the emergency department for nonemergent care.

The findings are presented in three sections: comments by hospital staff, emergency department and urgent care clinic chart samples, and patient interviews. Because the data were collected in three parts, the information could be presented or read in any order. I have chosen to present staff comments first because this was information that I immediately began pursuing when starting this thesis project. Also, this information allows the reader to gain some background thoughts on the subject before being introduced to the other two sections of this chapter. The staff comments are straight forward and stand on their own without interpretation. These comments are presented with minimal comment or analysis.

Comments by Emergency Department and UCC Staff

The Emergency Department and Urgent Care Center staff at Salem Hospital provide experienced insight into utilization of these facilities for nonemergent care. Information obtained from staff about ED use include patient's negative perceptions of the treatment they receive in a primary health care setting, the difficulty and frustrations that patients experience when trying to gain entrance to primary health care providers in an office setting, and the staff's perception that there are a particular group of patients for whom the ED provides an avenue for seeking narcotics and other prescription drugs outside of their regular source of care. In general, their point of view is that there are many complex reasons why patients seek nonemergent care in the ED.

ED physician - "The reason that people come to the ED has little to do with actually having a primary care physician. A lot of people choose to come to the ED because of the way they are treated, not just by the physician, but by other staff members within the office setting. If the receptionist is perceived as not being receptive, or if they get put on hold for long periods when phoning for an appointment, people get discouraged and come here."

ED physician - "We, meaning the public, the medical profession, and the legislature, have developed a system [the ED] to serve these people and then criticize the people for using it."

4-FT Nurse - "The system is becoming so complicated. It didn't use to be like this. Last week I was trying to get a prescription or an appointment for my daughter because she had an ear infection. These [ear infections] are not uncommon for her so I knew what was wrong. I don't have...[HMO] although it feels like that because I had to explain the situation to multiple people in the doctor's office. I was put on hold multiple times. And then I had to wait for a call back. It is really frustrating."

Triage Nurse - "I think medical groups are becoming larger and larger and they are losing sight of individual patients."

Admitting Clerk at UCC- "I used to work at one of the other urgent care clinics in Salem. Other clinics can refuse patients. We don't. The clinic I worked at had made arrangements to bill some of the insurance companies. If the patient has no insurance then they were required to pay up front or they were turned away."

Admitting clerk at 4-FT - "I used to work for[clinic] as a receptionist. I had to screen prospective new patients on the phone when they called to ask if we were taking new patients. We [receptionists] were given a questionnaire to ask these people over the phone. One question asked is if they were in good health? We had to ask what kind of health problems they had. We then would give the filled-out questionnaire to the doctor. The doctor would check the box either yes or no. They [the doctors] did not want patients with chronic problems. The receptionist would then be responsible to call the person back and say the doctor is taking or is not taking new patients dependent on the checked box. Some of the doctors really were not taking new patients because they had a full practice. Others would take new patients only if they didn't have chronic problems." This same receptionist stated that while she worked for this clinic she could be seen by the doctors within the clinic. Since leaving the clinic she had problems obtaining a new physician. "I called every family practice doctor in Salem. I had to go to Stayton to find one taking new patients."

Triage Nurse - "As a triage nurse it is hard to imagine trying to triage patients over the phone. I use all my senses to triage patients. At some of the doctors' offices the nurses are required to triage people with and without chronic illness through phone screening. I would feel uncomfortable doing this if I couldn't at least see them.

These nurses decide when a patient should be seen by asking them questions on a list of approved protocol. I couldn't do this."

Triage Nurse - "People who frequent the ED can usually be put into two categories; Frequent fliers are people who want to come in, think they are in crisis, generally are not, but often they do have some sort of a problem. ER abusers are people who want to come in, usually wanting narcotics, and they often could go to their own doctor but come here."

The staff also shared some of their frustrations of working in the ED. These feelings of frustration are caused not only by some of the patients and families who utilize the ED, but also the frustration of dealing with various insurance and primary care providers.

Triage Nurse - "ED use goes up after any meal, after church on Sundays, and after major games on television. People have other things to do and come to the ED when it is convenient."

4-FT Nurse - "People bring their children in after 10 PM so that medications can be charged on the bill. (Most pharmacies close by 10.) They tell us they can't afford prescriptions for their children but they have cigarettes. We are glad they bring the kids in though. We just wish they would bring them in earlier in the day."

Triage Nurse - "You ask some of these parents if the child has had a fever and they say, "I don't know. I don't have a thermometer". It is really frustrating when they say they can't afford to buy a thermometer for their child but they can afford cigarettes."

Admitting Clerk in ED - "There are so many different requirements within the insurance groups as well as the individual physicians that we can't memorize them. The specifics are put into the computer so we know what to do. When we enter an insurance number it tells us if we have to call the HMO for clearance. We always have to call on the OHP patients. It is so complex with so many different policies that someone needs to update the computer every month or so. Protocols for specific doctors are different too. Some [doctors] want to be called for every patient and others don't require it or even want to be called. There is no such thing as absolute. Things are likely to change."

During my observation at the triage desk I found the staff to be extremely tolerant of many types of patient and family behaviors. People do not always present themselves at the triage window as cooperative individuals. Some of the patients and/or families arrive in the ED exhibiting negative attitudes and behaviors including various degrees of intoxication and hostility. Although this is another cause of frustration for the staff, I found them to be compassionate and supportive of almost all of the patients and their families. The staff

often expressed concern for the less fortunate within the community. Some of the staff members are actively involved with various organizations who offer services to the underprivileged.

Triage Nurse - "You don't always know if someone is homeless unless you prod. The other day a whole family came in for one member to be seen. I asked one of the children about their house and was told, "we live in our car"."

Triage Nurse - "When you work in the ED it helps to know about the services that are offered in the community so we can tell patients where to go for help. For example, people can get vouchers for one set of clothing at different places in town like the Veterans or Goodwill. Sometimes different places call and ask for help and we collect the items. We [ED staff] collect things for the Union Gospel Christmas packages. Things like sox, toothbrushes, combs, deodorant, and shampoo. We also bought underwear for the Women's Crisis Center."

Triage Nurse - "Last month a man came in complaining of extreme pain in his hands. His problem was that he lived on the street, it is winter, and his hands were being exposed to the elements. I found him a pair of gloves in the lost-and-found barrel and encouraged him to try and find a warmer place to sleep at night such as the Union Gospel Mission."

Triage Nurse - "One observation I've made is that the sicker the person is, the further they sit from the triage desk. I really keep my eye on these patients even if they seem to have minor complaints."

Emergency Department and Urgent Care Clinic Chart Samples

The findings in this portion of the chapter will be presented using the two medical services utilization models as a structure for presentation. These models were discussed in the literature review (Chapter 2) of this thesis.

Emergency Services Model

The first model suggests that emergency departments play three major roles in health care and delivery: they serve as trauma centers, they provide a temporary source of care for those whose regular provider is unavailable, and they serve as a regular source of care for the poor.

The accuracy of the triage numbering system as well as the role of the ED as a trauma center may be assessed by looking at the study population and hospital admissions. All of the 462 patients in the ED sample were triaged as 4 or 4-FT. The triage process found none of these patients to have life threatening conditions or to be in need of immediate medical attention. Of these patients 36 had been admitted to Salem Hospital at least once during the year (June 30, 1994, to May 31, 1995). Thirty-three patients had been admitted directly to the hospital by a physician without first being triaged from the emergency department. Three had been admitted from the ED at some time during the year. However, none of the patients was admitted from the ED during the sample dates in question in which they were triaged as either a 4 or 4-FT.

Of the 183 patients in the Urgent Care Center sample, 17 had initially presented to the emergency department before going to the UCC. Either during the screening process or the admission process, these patients had gone from the ED to the UCC to obtain their care. It is difficult to know from the charts which of the patients chose to go to the UCC after the screening nurse provided this as an option, or if the admission clerk, when calling for insurance authorization, was instructed to have the patient go to the UCC for care. Again, it is important to remember that the ED would not have refused care to these patients if they had chosen to receive their care in the ED rather than the UCC. However, for those patients with certain types of insurance coverage, particularly those with managed care policies, reimbursement to the hospital for medical treatment may be withheld if prior authorization is not obtained. If, for example, authorization was obtained for the patient to go from the ED to the UCC and the patient instead chose to obtain care in the ED, the patient may be held liable for the cost of the ED visit. Six of the patients who went from the ED to the UCC were private pay and may have chosen to do so because of personal preference when given the option. At least three of the patients were from managed care groups which may have authorized treatment at the UCC.

Five patients presented to the UCC and were directed to the ED to receive their care. After an initial evaluation these patients were found by UCC staff to have medical needs which were beyond the scope of care which they felt should be provided at this facility. Of particular interest was one female presenting with symptoms of fever, chills, and headache. She had just returned from Africa two days prior. She was evaluated in the ED, assigned a

triage number of three, and was admitted to the hospital to evaluate for malaria. There were no other patients from the sample who were admitted to the hospital after being referred from the UCC to the ED. This demonstrates that the majority of patients (88%) who utilized the UCC are able to appropriately triage themselves or be triaged over the phone by their doctors or office staff to the Urgent Care Center without first being evaluated in the ED.

Use of the ED and UCC may be evaluated as a temporary source of care, such as when a regular source of care is unavailable, by how many people use these facilities during regular business hours. Although it is not within the scope of this paper to determine exact hours for individual primary care providers, 9 to 5 - Monday through Friday might be expected hours for the majority of providers. Particular offices, especially large groups of physicians providing managed care, are known to offer some evening and weekend office hours. Alternatively, not all providers may be available every day during the week. When looking at the findings, therefore, it is important to keep in mind that alternative hours may be available for some patients, while others may be more limited in provider availability.

Of the 462 patients who used the ED for care, 112 (24%) used it Monday through Friday from 9AM to 5 PM, while 350 (76%) used it at other times. This differed from the UCC use where, of the 183 patients, 77 (42%) used it during the week from 9am to 5pm and 106 (58%) used it at other times. The percentage difference between the ED and UCC utilization during regular office hours and after hours may be due to the fact that the UCC does not see patients before 10 AM or after 9 PM. Of the patients utilizing the ED, 130 (28%) presented to the facility between the hours of 9 PM and 10 AM. Thus, the time of day in which providers are available to see patients may have a considerable influence on ED use. Although many groups of providers are expanding their hours to include evenings and weekends, it is possible that some patients are unaware of this and continue to rely on the ED or UCC as their only option. Another possibility is that not all patients find it possible or convenient to make scheduled appointments.

The ED as a usual source of care for the poor can be examined by looking at medical insurance coverage. Of the 462 patients from the ED sample, 25% were either on the Oregon Health Plan (OHP) or Medicaid and 21% were uninsured. Of those in the UCC

sample, 20% were covered by the OHP or Medicaid and 22% were uninsured. More than 50% of those from the chart samples using these two facilities for nonemergent care had other types of health insurance coverage. This suggests that the ED and UCC serve more than just the underprivileged population.

The Behavioral Model of Access

The second model employed to analyze emergency services utilization is the behavioral model of access. This model of access suggests that health services can be explained as three sets of factors: predisposing factors (age, gender, family, and other social networks), enabling factors (insurance coverage, income), and need factors (factors which represent the need for health services, either real or perceived needs).

1. Predisposing Factors

Findings from the chart samples on age as a predisposing factor were fairly consistent with those found in the literature review in that the majority of people seeking care in the ED for nonemergent conditions are between the ages of 17 and 40 and that children under the age of five disproportionately use the ED as compared to older children. In my study the ages of the patients who used the emergency department for nonemergent care ranged from eight days to 90 years of age. Those using the Urgent Care Center were similar in age ranging from six months to 83 years of age. The average age of those from the ED sample is 28.7 and that of the UCC is 29.5. One hundred and two (22%) of the ED population and 46 (25%) of those in the UCC population are under the age of 17. Of these 50 (49%) from the ED sample and 15 (33%) from the UCC sample are under the age of five. The age group of the ED sample which shows the greatest variance from that of the estimated 1994 population census for Marion County (Center for Population Research and Census, Portland State University) is between the ages of 15 and 39. Thirty-six % of the general population and 56% of the ED sample fall within this age group. From this same population estimate, the ED sample closely reflects the percentage of those under the age of 15 with these being 23% and 21% respectively. This same population source shows that 41% of the general population for 1994 are over the age of 39 while only 23% of those utilizing the ED for nonemergent care are over the age of 39. Of the 462 patients in the

ED sample, 219 (47.4%) are male and 243 (52.6%) female. Of the 183 patients in the UCC sample, 85 (46.4%) are male, and 98 (53.6%) female. This compares closely with the estimated 1994 population census for Marion County in which there are 51% female and 49% males (Center for Population Research and Census, Portland State University). From both samplings there was a decline in the number of those over the age of 45 seeking nonemergent care. It is possible that at this age there may be a tendency to develop chronic problems in which patients may regard receiving health care by a regular provider of greater importance. Another possibility is that those older than 45 continue to be seek care in the ED but are triaged at having a higher level of need.

According to the literature review, social networks may influence emergency department utilization. Of the 347 people in the ED sample who were 18 years of age and older, 168 (48%) were male and 179 (52%) female. Information obtained from the ED charts indicated that 39% were married, 45% were single, 13% were divorced, and 3% were widowed. From the Urgent Care charts there were 134 people over the age of 17 with 61 (46%) being male and 73 (54%) female. Of these, 42% were married, 48% were single, 9% were divorced, and 1% were widowed. These findings suggest that marital status is not a significant differentiating factor in ED and UCC utilization. As mentioned previously, initial patient interviews suggested that marital status may not be a good indicator of social networks. Many individuals live in households that have multiple members who may or may not be related.

The literature suggests that children of single-parent households utilize the ED more frequently than those from two-parent households. Information obtained from patient charts does not include documentation of single versus married status of children's parents. However, the patient admission document does have a space to list both parents as well as pertinent information such as each parent's address. Admission clerks told me they attempt to obtain information on both parents and those listing only one parent are very likely to be single-parent households. With this in mind, the ED chart sample shows 115 children and the UCC shows 49 children under the age of 18. (See Table 2 - Children by Guardians Listed) Between the two facilities the percentage of seemingly single-parent and two-parent households was almost identical and demonstrates that just over half of the children in the sample were from two-parent households. It would be interesting to compare my results

with family status at other types of facilities, such as private office settings, to see if utilization rates in the community are consistent with the literature.

Table 2 Children by Guardians Listed

No. Of Parents Listed	ED	UCC
Both Parents Listed	69 (60%)	29 (59%)
One Parent Listed	40 (35%)	18 (37%)
No Parent Listed	6 (5%)	2 (4%)

Information obtained on patients in my study does allow for a comparison in regards to ED and UCC utilization over a year time. What I found is that the average number of visits by children in apparently single-parent households is about the same as that of visits by children in apparent two-adult household. Of those from the ED sample there were 1.7 visits for the year by the children from two-parent households and 1.9 visits by the children in single-parent households. From the UCC sample there were 1.5 visits for the year by the children of two-parent households and 1.8 visits from single-parent households. (The UCC findings are based on combining the eight ED visits and 35 UCC visits for this group over a year. There were no UCC visits for those in the ED sample.)

According to the literature, cultural factors may have an effect on nonemergent ED utilization. During the chart review process I found that many of the admission sheets lacked accurate documentation of ethnicity, often leaving this area blank. Discussion with admitting staff revealed that this may have been an oversight during busy times or an indecision as to how to categorize ethnicity based on a patient's physical appearance. After doing hours of observation in both facilities, I would conclude with hospital staff that in regards to ethnicity, utilization rates, by observation, seem to be fairly consistent with the general population in the Salem area. The majority of patients are European-American while utilization by the Hispanic population is second in number.

2. Enabling Factors

Insurance coverage and access to a primary care provider have been found to be strongly associated with ED use, with those on public assistance and the uninsured more likely than others to utilize the ED as their regular source of health care. Of those in the ED chart sample, 114 (25%) were on either the Oregon Health Plan (OHP) or Medicaid and 96 (21%) were uninsured. Of these, 62% of those on the OHP or Medicaid listed a primary care provider, while of the uninsured, only 27% listed a provider. Of those in the UCC sample, 36 (20%) had insurance coverage either through the OHP or Medicaid and 41 (22%) were uninsured. Of those with either the OHP or Medicaid coverage, 61% listed a primary care provider, while only 22% of the uninsured listed a provider (See Table 3 - Comparison of Insurance Types and Patients With and Without Primary Care Providers). This compares with patients covered by other types of insurance in which 70% of those using the ED and 68% of those using the UCC list a primary care physician. These findings are consistent with the literature review in that having health care insurance increases the likelihood of having a source of health care outside of the ED. The findings are also consistent with the literature in that those on public assistance may have more difficulty locating a provider who will accept them into their practice compared to those with other types of insurance coverage and thus utilize the ED/UCC for nonemergent care.

Table 3 Comparison of Insurance Types and Patients With and Without Primary Care Providers

Insurance Type	ED Patients With PHC Provider	ED Patients Without PHC Provider	UCC Patients With PHC Provider	UCC Patients Without PHC Provider
OHP/Medicaid	71 (62%)	43 (38%)	22 (61%)	14 (39%)
Uninsured	26 (27%)	70 (73%)	9 (22%)	32 (78%)
All Others	177 (70%)	75 (30%)	68 (64%)	38 (36%)
Total	274 (59%)	188 (41%)	99 (54%)	84 (46%)

An interesting finding is that children are more likely than adults to list a primary care provider. Of those from the ED sample, 55% of those 18 years of age and older list a primary care provider while 75% of those under the age of 18 list a provider. From the UCC sample, 46% of those 18 years of age and older list a provider, while 76% under the age of 18 have a provider listed. One possible explanation of the higher rate of children having a provider is that primary care physicians may be more likely to accept new patients if they are children. Also, capitated reimbursement systems may enhance a child's chance of finding a primary care provider while having an adverse affect on access for adults due to the added possibility of chronic health problems. Another possible explanation is that there may be greater value placed on having a primary provider for a child. This finding does not verify that these children have actually had office visits with their primary care provider but may indicate that there is a greater potential for children to utilize providers outside of the ED and UCC.

According to the literature, employment as an enabling factor does not significantly affect ED utilization. In this study, there were more employed adults presenting in the ED and UCC for nonemergent needs than those who were not employed. Of the 347 persons over the age of 17 from the ED chart population, 57% were employed, 30% were not employed, and 13% consisted of those who stated that they were either retired or students. From the UCC chart sample there were 134 people over the age of 17. Of these, 61% were employed, 23% were not employed, and 16% were retired or students. It is unclear from the chart information if employment was full-time, part-time, or seasonal. This would be an important element to examine if employment were to be considered as a significant enabling factor . For example, the Salem area provides many job opportunities in agriculture which tend to be seasonal. Also, information is not available to determine which of the patients in the sample are not employed outside the home - for pay - because of choice or because they lacked work opportunity. From my study what is known is that more than half of the adults in the samples stated they were employed. This finding suggests that employment, as an isolated factor, may not be a strong indicator of ED and UCC utilization.

Employment status did not affect the time of day of those who used either facility. Of the 197 employed adults using the ED, 25% presented from 9-5 on the weekdays while 23% of those not employed presented at these times. Of those using the UCC, 49% of the employed adults and 45% of the non-employed adults presented between 9-5 during the weekdays. As stated earlier, the UCC is only open until 9 p.m. which would affect the proportion of patients utilizing it after regular office hours.

As reported in the literature review, proximity to the ED as an enabling factor may influence utilization. Salem Hospital as well as the Urgent Care Clinic are located in the 97301 Zip Code area but also lie on the border of 97302 (See Figure 2 - Zip Code Map). In fact, Salem Hospital lies fairly close to the exact center of the Salem-Keizer area. The largest number of persons utilizing either the ED or the UCC lived in the 97301 Zip Code area (See Table 4 - Zip Code Area and Utilization). Of my study population, 21% of those who utilized the ED and 22% who used the UCC were from the 97301 Zip Code area. This is not substantially different from those in the 97302 and 97303 Zip Code areas. Of interest is

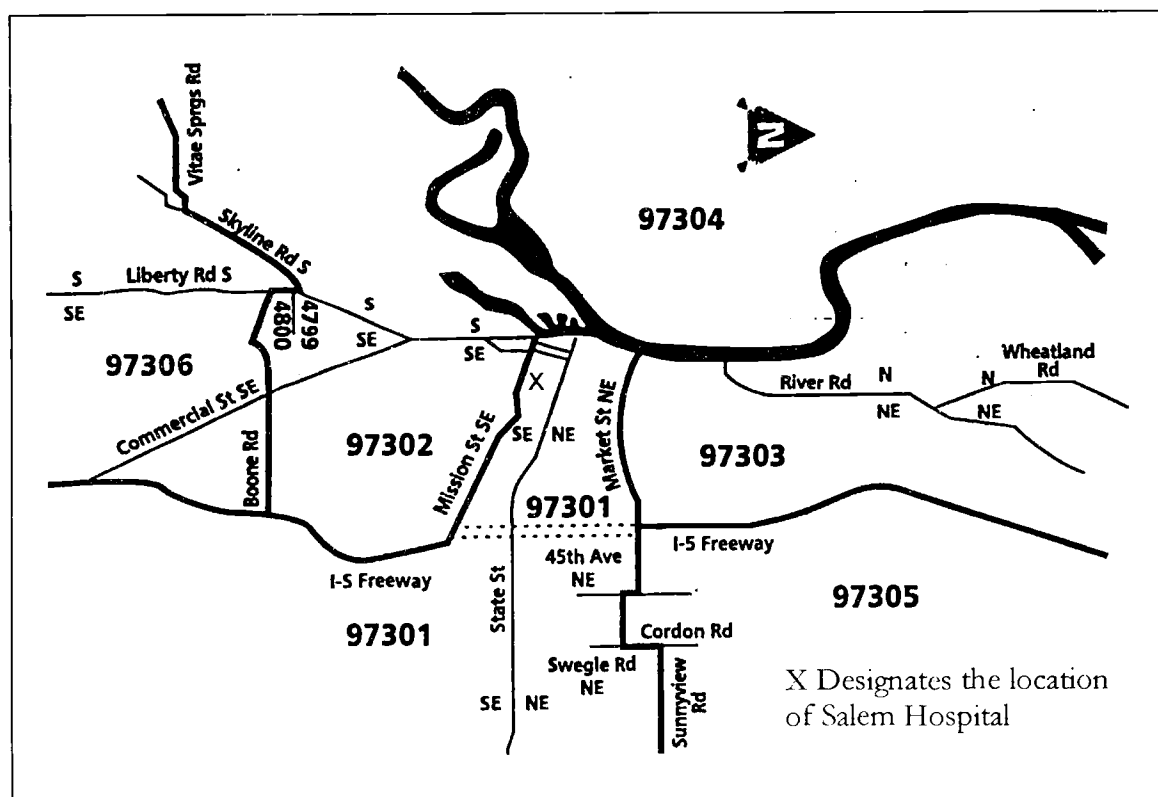


Figure 2 Zip Code Map

that of those from the ED sample, 49% from the 97301 area, 51% from the 97302 area, and 50% from the 97303 area were either on the Oregon Health Plan/Medicaid or they were uninsured. These numbers closely coincide with the 46% which represent the total population within these insurance types. When comparing the percentage of population by Zip Code area of the ED sample with that of the 1990 Census Report (Center for Population Research and Census, Portland State University) I found that of those living within the 97301 through 97306 Zip Code areas, 27% of the ED sample population and 27% of the total population lived within the 97301 area. This demonstrates that ED utilization is fairly consistent in regards to socio-economic factors throughout the Zip Code areas and that ED utilization by Zip Code is a manifestation of population density rather than an indication of proximity to the hospital.

Table 4 Zip Code Area and Utilization

Area	ED	UCC
Zip 97301	97 (21%)	41 (22%)
Zip 97302	83 (18%)	32 (18%)
Zip 97303	82 (18%)	35 (19%)
Zip 97304	25 (5%)	7 (4%)
Zip 97305	53 (12%)	23 (13%)
Zip 97306	25 (5%)	8 (4%)
Within 20 Mile Radius	61 (13%)	20 (11%)
20 to 30 Mile Radius	5 (1%)	2 (1%)
Greater than 30 Mile Radius	16 (4%)	7 (4%)
Out of State	14 (3%)	8 (4%)
Out of Country	1 (0%)	0 (0%)

3. Need Factors

Need factors, such as the presence of chronic health conditions or a patient's perception of their own health status may influence emergency department utilization. According to the literature review, psychosocial stressors may have a greater impact on ED use than other recurrent health conditions. It is not within the scope of this paper to evaluate which patients may have psychosocial needs versus other types of medical conditions. However, it is possible to look at patients' presenting complaints and diagnosis.

Of those in the ED sample, 52% presented with complaints of an illness while 48% presented with complaints of an injury. Of those presenting with complaints of injury, 55% were male while only 40% of those with complaints of illness were male. From the UCC sample, 55% presented with complaints of illness and 45% with complaints of injury. Of these, 43% with complaints of an illness and 51% with complaints of an injury were male. This shows that there are fewer numbers of nonemergent patients presenting with complaints of injury as compared to illness. It is very likely that those with more serious injury go to the ED instead of the UCC and that they would be given a triage number reflecting the seriousness of their injury. By examining the numbers of patients complaining of an illness versus injury it would appear that there is little difference between the two facilities in the types of complaints and that these medical problems might be adequately treated at either facility.

As mentioned in the literature review, males, particularly those in their late teens and early 20s, are especially prone to injury. In my study, 27% of the males from the ED population were between the ages of 15 and 24. Of these, 68% presented with complaints of an injury. Twenty-four percent of the females fall within this same age group and of these only 38% presented with complaints of injury. Of those from the UCC population, 19% of the males and 20% of the females were between the ages of 15 and 24. Of these 56% of the males and 30% of the females presented with complaints of injury. This finding shows that there is a gender difference between those presenting to the ED and UCC with complaints of illness and injury, particularly among young adults, and that this corresponds to conclusions found in the literature. Another way in which to view needs factors and general health status is to look at patient diagnosis. (See Figure 3 - ED and UCC Utilization by Diagnosis.) Of those utilizing the ED, lacerations accounted for 18% of the nonemergent visits with musculoskeletal system disorders being next in frequency (17%). This is in contrast to psychiatric related disorders of which there were only 2%. The most frequent diagnoses of those utilizing the Urgent Care Clinic differed from those in the ED sample. Of those in the UCC sample the most common diagnosis, accounting for 24% of the visits, involved the ENT (eye, ear, nose and throat) systems. Skin related diagnosis was the next most common and it accounted for 18% of the visits. No patients in the UCC sample were given a psychiatric related diagnosis. There is a distinct percentage difference in

patient diagnosis between the emergency room population and the Urgent Care Clinic population. Patients may present to one or the other of these facilities for care based on their perception of the severity of their medical problem. For example, visualizing blood coming from even a small laceration may cause fear or other emotions which may increase the likelihood of a patient deciding to go to the ED instead of the UCC for care. Although ear infections are uncomfortable, it may be more difficult for a patient/parent to perceive ear discomfort as a true emergency and may be more likely to go to the UCC. Self triage is difficult and may be a barrier for patients to utilize the UCC appropriately. There seems to be a greater tendency for patients to seek nonemergent medical attention in the ED than for patients with more serious conditions to seek care at the UCC. Considering the potential for patients to underestimate the seriousness of their problem, being triaged from the ED to the UCC for nonemergent care would seem a reasonable solution. (See Appendix C - For a detailed account of the ED and Urgent Care Clinic patient diagnosis.)

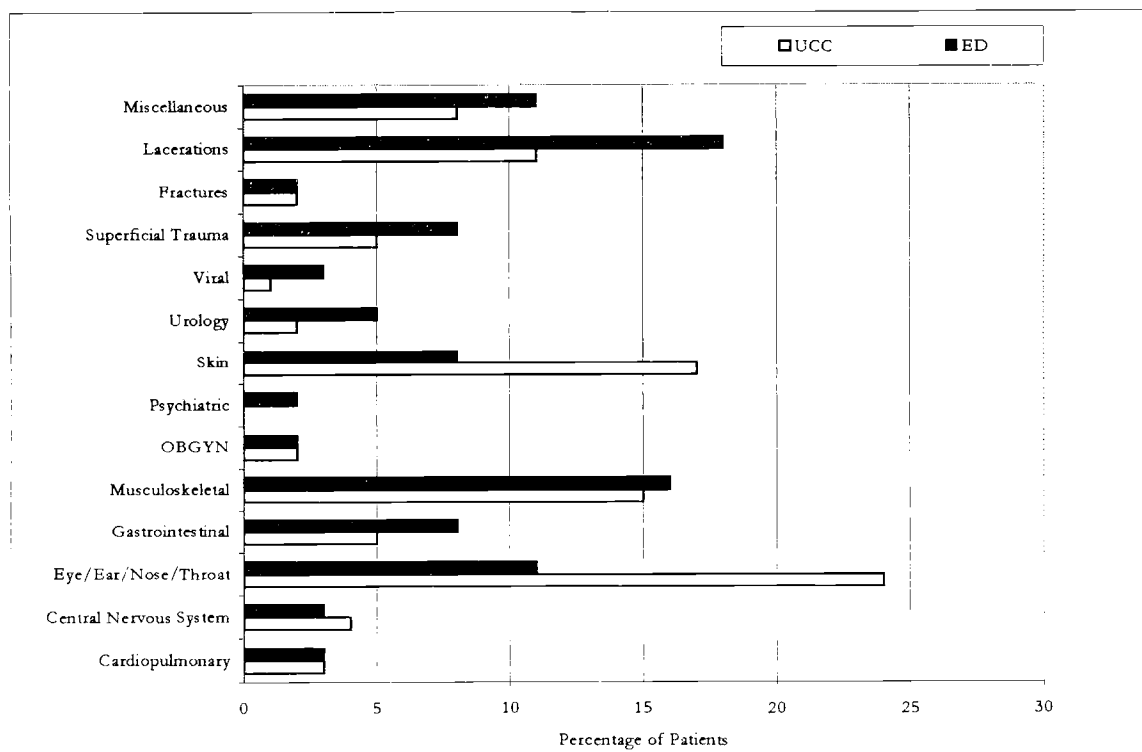


Figure 3 ED and UCC Utilization by Diagnosis

In summary, information from the chart reviews was informative showing who utilizes the ED and UCC for nonemergent care and why. Data obtained during the reviews show that there are a variety of types of patients who use these facilities and that there is not a single strong factor indicating utilization but that multiple factors are important. Many similarities were found between the population which use the ED and UCC at Salem Hospital and information found in the literature review. Age is an important factor in that the very young (under the age of five) and those in their 20's account for almost half of the nonemergent visits. (Forty-eight percent of the ED and 41% of the UCC sample.) Socio-economic features such as being on public assistance or being uninsured are also important factors when looking at who uses the ED and UCC for nonemergent care. Over 40% of the patients in the chart reviews were either on Medicaid/OHP or were uninsured. There was also a greater number of patients covered by the OHP/Medicaid or uninsured who lacked a primary care physician as compared to those covered under other types of insurance.

Emergency departments provide access to care for patients with symptoms which may be painful, worrisome, or uncomfortable. Although many patients who seek medical care in the ED have nonemergent problems, it may not always be easy for patients or their families to evaluate the severity of their medical conditions. There is a difference in medical conditions between those seeking care in the UCC and those seeking care in the ED. Although these patients have been triaged as nonemergent by staff, there may be some difficulty in patients identifying their needs as nonemergent and thus will continue to present to the ED.

Those Who Utilize the ED and UCC for Multiple Visits

An additional way in which to evaluate utilization is by looking at the number of repeat visits. According to Padgett (92:1189), "about 11% of the U.S. population visited a hospital emergency department in 1980. However, it is known in both the U.S. and abroad that a small number of patients account for a disproportionate share of all ED utilization by virtue of repeat visits". On the average, the general population visits a physician five times each year (Sultz and Young, 1997; Weiner, 1994). If the emergency department or Urgent Care

Clinic is the primary source of care for a portion of the population, utilization of the facilities beyond five visits could be considered excessive. In this study it is not known which of the patients used only the ED or UCC at Salem Hospital and which may have used other providers. For example, listing the name of a primary care provider is not the same as actually utilizing that provider. It also does not include visits which may have occurred with additional providers such as other urgent care clinics, emergency departments or other health care providers.

From June 1, 1994, through May 31, 1995, the 462 patients from the ED sample visited the ED 1075 times with an average of 2.3 visits. However, 263 of the patients visited the ED only once during the year. As discussed earlier, more than five visits could be viewed as more than average even if the ED at Salem Hospital was their only source of health care. Thirty-four patients utilized the ED more than five times during the year, accounting for 367 visits or an average of 10.8 visits. What this demonstrates is that 57% of the ED population used 24% of the total ED visits and 7% of the population used 34% of the visits. (See Figure 4 - ED Utilization and Total Number of Visits.) The numbers of multiple users are slightly less for the Urgent Care Clinic in that 6% (11) of the sample population used 27% of the 364 total UCC visits. These are significant numbers when looking at who uses the ED and the UCC for nonemergent care. Utilization of this group of patients was studied separately and the results of these findings are presented below using the behavioral model of access. To provide consistency in terminology, "multiple user" is the term used when describing those who utilized the facilities more than five times during the year.

It is important to mention that there were 11 patients from the Urgent Care Center population (June 1, 1995 to May 31, 1996) who used both the UCC and the ED with a combined total of more than five times. These were not included in the multiple user subgroup of the UCC because they had not used the UCC more than five times. Between the two facilities these patients had 85 total visits with an average of 7.8 visits. This demonstrates the potential of certain patients to obtain care from multiple providers and the difficulty of accurately tracking utilization.

1. Predisposing Factors (Age, Gender, Family)

There were only slight differences in predisposing factors when comparing the total population with those who used the facilities more than five times within the year. The age of multiple users did differ from that of the general population's in that there were fewer children in the multiple user category. The number of children utilizing both facilities represents about one-quarter of the total population while children represented only 9% of the multiple user ED population. There were no multiple users under the age of 18 within the UCC sample. Gender and marital status did not substantially differ between the multiple user group and that of the total sample population.

2. Enabling Factors (Insurance Coverage, Income)

Differences were found in enabling factors when comparing the total ED and UCC populations and those of multiple users. Within the ED multiple user populations those covered by the OHP/Medicaid were more than double those of the total population (53% as compared to 25%), while the number of the uninsured was 21% as compared with 18%. Within the UCC population the uninsured multiple user population was more than double that of the total sample (55% as compared to 22%). The percentage of those covered by the OHP/Medicaid from the multiple user UCC population was 27% as compared to 20% for the total population. As compared to the total ED population, multiple users listed a primary care provider more often (65% versus 59%). The opposite occurred within the UCC population in that 54% of the total population listed a provider while only 18% of the multiple users listed a provider. This finding may be due to the larger percentage of multiple users who are uninsured as compared to the total population. This corresponds with the literature in that the uninsured are believed to be less likely to find a primary care provider who would accept them as patients.

As mentioned earlier, employment as an enabling factor does not seem to be a significant determinant in ED utilization. When looking at the total ED population it was found that 30% of the ED population over the age of 17 were not employed while in the multiple user group this percentage is almost double at 52%. Twenty-three % of those of the total UCC population and 36% of the multiple users were not employed. This finding

may indicate that those who utilize the facilities more than five times a year may have real or perceived poor health and subsequently be less employable. An additional possibility is that the uninsured may have more health concerns.

Proximity to the hospital as an enabling factor for ED multiple users is fairly consistent with that of the total population with the exception that 26% of the multiple users lived in the 97302 Zip Code area. The total ED population from the same area was 18%. The 97301 and 97303 areas remained fairly constant in comparison. (Salem Hospital lies in the 97301 Zip Code.) The Zip Code areas of those from the UCC multiple users did not differ significantly from the total and were fairly evenly distributed.

3. Need Factors (Both real and perceived)

Differences were found when comparing need factors of the total population with those of the multiple users. Sixty-eight % of the multiple users from the ED population complained of illness as compared with the total ED population in which 52% complained of an illness. Within the UCC population the percentage of those with complaints of illness was 55% for the total population compared to 45% for the multiple users. Looking at patient diagnosis concurrently with patient complaints of illness or injury helps to make this more comprehensible.

Within the total ED population, lacerations (injury) accounted for 18% of the diagnoses. This compares with the multiple user ED group in which only one person (3%) was seen for a laceration. On the other hand, 18% of the multiple users from the ED had complaints of headache/migraine (Central Nervous System) versus 3% percent for the total ED population. As in the total ED population, the diagnosis of musculoskeletal system remained second in frequency, accounting for 15% of the multiple user utilization and 17% of the total population. The third most frequent diagnosis for the ED multiple user group was psychiatric related disorders. It accounted for 12% of utilization while in the total ED population this was only 2%. Of those from the UCC multiple users, 55 % (six) had a skin related diagnosis as compared with 18% from the total UCC population. All of the skin related diagnoses of the multiple users were due to cellulitis/infection. Two of these were directly related to IV drug injection. Many of the repeat visits within this diagnosis were for

follow-up dressing change/wound care. The next most frequent diagnosis of the UCC multiple user is that involving the musculoskeletal system, being 18% versus 15% for the total UCC population.

In summary, over half of the multiple users from the ED sample had insurance coverage through the OHP/Medicaid while over half of the multiple users from the UCC were uninsured. From these same groups, employment status also differed from that of the total populations using these facilities, especially within the multiple users of the ED in which over half were not employed. Diagnosis of multiple users from both locations also differed from that of the total populations. These differences indicate that some of the patients who utilize the ED and UCC more than five times during the year may have needs which are beyond the scope of the nonemergent classification. An increase in the number of psychiatric related diagnosis of multiple users seeking care in the ED, and, the diagnosis of infection directly related to drug injection of two patients from the UCC multiple users, are direct indicators of the complexity of this group. This information highlights reasons why some of the multiple user patients may have an increased likelihood of being dependent on the ED and UCC for their medical needs.

Individual Profiles of Multiple Users

To better understand attributes of multiple users of the ED, utilization profiles of five individuals are presented below. This information was obtained from the computer at the ED triage station. A summary of their utilization for the year (June 1, 1994, through May 31, 1995) is described. They may not be representative but are given here to provide an illustration of ED multiple users.

Patient One - This is a 37 year old male with insurance coverage listed as the OHP. He does not list a regular physician, is married, unemployed, and has a history of Methadone treatment. This patient was seen in the ED 27 times and the UCC four times during the year. There seemed to be no particular pattern to his visits. He arrived three times by ambulance; twice he came for possible seizure activity and once for complaints of leg

numbness and headache. He was seen multiple times for complaints of pain in various body areas, had complaints of chills, fever, dizziness, weakness, and came with requests for explicit medication refills. Twice he complained that his vehicles had been stolen along with his prescription medication. He refused some of the medication prescriptions offered by the ED physicians and at times became agitated if his requests for specific medication preferences were not prescribed. He requested medications for pain as well as for alleged seizure activity. The physicians in the ED had given him multiple referrals for neurological evaluations, but the patient apparently did not follow-up. He was not admitted to Salem Hospital during the year. The emergency department staff was very familiar with the patient and referred to his ED utilization as "drug seeking". They also believed that he was currently incarcerated.

Patient Two - This is a 47 year old female patient with insurance coverage through Blue Cross/Blue Shield. She lists a regular physician and is both married and employed. This patient was seen 22 times in the ED and once in UCC over the year with complaints of migraine headache. Her visits were spread throughout over the year and included all days of the week excluding Mondays. She was given a referral to a neurologist on at least two of the visits although there were no out-patient diagnostic studies through Salem Hospital (such as a CT scan) which would indicate that she followed up with the referrals. There were no admissions to Salem Hospital. Hospital ED staff were not familiar with her name and seemed surprised that they had not recognized her as a multiple user of the ED considering the number of visits. I discussed the case with two ED physicians who described her ED utilization as "probable drug seeking behavior".

Patient Three - This is a 17year old male with insurance coverage through the OHP and has a primary care physician listed. He has a very complicated family history with his father having been murdered a few years prior and his mother committing suicide the following year. It was unclear from the chart with whom he had currently been living. The nonemergent visit by which he became part of the patient ED sample was for a contusion of his hand after hitting a wall while agitated. There were eight other visits to the ED during the year for various complaints. He came by ambulance three times. Once after an auto accident with a pseudoparalysis (apparent paralysis due to voluntary inhibition of motion because of pain or other cause). The next day he came by ambulance with a possible

concussion and alleged seizure activity. Another was for complaints of chest pain for three months. On this visit he was given a Marion County Mental Health referral. He had also been seen for bronchitis, complaints of hand pain, twice for complaints of abdominal pain, and once for combative behavior. He had no admits to Salem Hospital during the year.

Patients Four and Five - This is a husband and wife who each used the ED eight times during the year. He is 44 and she is 41 years old. He is self employed, she is unemployed, and they both are uninsured. They live in Oregon but farther than 30 miles from Salem Hospital. There are two hospital emergency rooms closer to their residence than Salem Hospital. According to the ED records he has a history of back surgery in 1992. He was seen in the ED eight times during five months with complaints of back and foot pain. She was also seen eight times during the same five months for complaints of headache and back pain. There were no visits by either of them for seven months. On the exact same month the following year, they began to again visit the ED at Salem Hospital. He visited the ED and UCC three times over the next 3 months while she was seen 4 times. I did not follow their utilization further. Upon discussing the case with an ED physician, I was told that this was "probable drug seeking behavior and because of the pattern of use they may also be utilizing other facilities".

Emergency Department and Urgent Care Clinic Patient Interviews

This section includes findings from the 24 interviews obtained in the ED/4 FT waiting room areas and 34 interviews from the UCC waiting room area. From the ED area this includes information on four additional people in that in two of the interviews both a parent and child were seeking medical attention and a third interview included information on three children from the same family who were being evaluated. Therefore, in total, there is information on 28 people from the ED/4 FT area.

As discussed in the methods section of this thesis, the questionnaire was semistructured in nature in order to provide organization and consistency in obtaining information as well as allowing for additional free flowing conversation to be obtained during the interview

process. Specific comments from patients or families during the interview process immediately follow the discussion of the particular question for which the comment was given. Individual patient/family remarks are denoted by an indentation.

Although multiple attempts were made to interview patients at various times of the day during the week, on many occasions the waiting rooms did not have a sufficient waiting period for interviewing to occur. This was especially true in the ED where nonemergent patients may be seen fairly soon after arrival. The length of the waiting period for nonemergent patients in the ED is directly affected by the number of patients with more emergent needs. For example, all patients with a triage number of one through three have priority and are taken directly to the treatment area after being evaluated by the triage nurse. Those with nonemergent needs receive their care when staff and exam rooms become available. For this reason, 82% of the ED and 56% of the UCC interviews occurred on the week-ends or in the evenings after four p.m.

Information obtained on patients was fairly equally divided between males (48%) and females (52%). Of these, 49 (79%) were European-American, 10 (16%) were Hispanic, two (3%) were African American, and one (2%) was American Indian. Fifty-two percent of the information obtained during the interview process concerns children under the age of 18. Of these, 74% of the interviews were completed with the mother of the child, 13% with the father, 3% with a grandmother, and 10% with a foster mother. (One of the interviews was completed by a 17 year old patient who was also the mother of a two year old patient.) Of the parents interviewed, 59% stated they were married, 22% single, 7% divorced, 4% widowed, and 7% separated. Of those over the age of 17, more than half (60%) described themselves as either single or divorced. One interesting finding is that some divorced individuals may prefer to designate their marital status as single. I found this to be the case in one interview in which I questioned a young women who initially said she was single. What is your marital status? "Single." You have never been married? "Yes, but I don't like saying I'm divorced. I'd rather say single because I am." What this may indicate is that data regarding marital status on single versus divorce could be incorrect unless the question of a previous marriage is specifically addressed.

All of the literature read for this thesis confine marital status categories to married, divorced, single and widowed. Information obtained during patient registration at Salem Hospital also limits information to within these classifications. During my interviews there were two people that indicated they were separated and numerous other interviewees who introduced the person with them as their fiancée. Therefore, depending on the purpose of questioning marital status, it should not be assumed that there is or is not a significant other in their lives based solely on the question of marital status.

How many people accompany the patient to the ED/UCC might be viewed as an indicator of either having a social network or of being alone. Of the 31 adult patients interviewed, 48% (15) were alone in the waiting area. Of these patients, six normally lived in other towns/states and became ill or were injured while in the Salem-Keizer area. Of those who lived within the area, two stated their wife/fiancé were working, one stated her fiancé was watching the children, one stated he was sent from work to be seen, and four complained of minor medical problems such as cold symptoms or a migraine headache. These four patients were interviewed at the Urgent Care Clinic and indicated that the severity of their medical problem was minor. The fact that they were utilizing the UCC for admitted nonemergent needs may account for not having a friend or family member to accompany them. However, there was one man, 62 years old, who stated he was disabled, lived alone, and through his conversation, seemed to be alone. Other than this one incident, loneliness did not seem to be a strong indicator of nonemergent utilization of the facilities.

Do you currently have a regular physician or other health care provider?

As discussed earlier in this thesis, utilization of emergency departments and free standing clinics, such as the Urgent Care Center, may be due to a lack of having a regular provider. From the interviews, I found that 74% of the patients lived in the Salem-Keizer area. Of those living in this area, 62% of the ED and 75% of the UCC patients stated they had a primary care provider. This demonstrates that less than half of those interviewed who live within the Salem-Keizer area may have used these facilities because they lacked, or believed they lacked, alternative places for receiving medical attention. However, statements made by patients/families describe the process of seeking a primary provider as often a very frustrating experience. Remarks made by some patients also indicate that not all patients

who have a primary care provider feel that they have a positive relationship with that provider. Other comments include cost as a barrier to obtaining a primary provider while others assert that they normally don't need a provider because they are in good health.

Yes. For about a year. I called many in Salem, Stayton, Scio, and Independence. It was frustrating to find one who would take the OHP. I would prefer a doctor not on an HMO list. One I chose. They treat you poorly if you are on the OHP. They don't spend time with you and they treat you differently. Maybe they have a hard time collecting from them [the State] or something. They [doctor] don't care about you as a person when you are on the OHP.

Kind of. I can't remember his name.

No. I had one but I am going to change because I don't like him.

No. Well, yes. I have never been assigned one that I know of. I have never needed one but would have one under their plan. I've been covered under [HMO] with the OHP for about four or five months.

I used to see a doctor in Mt. Angel. I did not have trouble re-establishing this doctor even though I now am on the OHP. Prior to about a month ago I didn't need a doctor because I was healthy.

No. We used to have[HMO] and were not satisfied with it but we liked our previous doctor. My husband has changed jobs and we are planning to return to our previous physician when we qualify for insurance next month.

I can't afford to have a doctor. I don't have insurance.

An interesting and somewhat predictable finding is that having a primary care provider seems to have a direct relationship to the length of time in which a person resides in an area. (See Table 5 - Having a Primary Care Provider and Length of Time the Patient/Parent has lived in the Area) The length of time in which the patient/parent had currently lived in a particular town varied from one day to 32 years. Those who had resided in an area for less than a year lacked a regular provider more often than those who had lived in the area for a longer period. Patient remarks indicate that, for some, moving to a new area has impeded their ability to obtain a primary care provider, while for others, this was not the case.

We move back and forth a lot between Oregon and Washington and we just moved back. (17 year old mother with two year old daughter.)

Table 5 Having a Primary Care Provider and Length of Time the Patient/Parent has Lived in the Area

Length of Time	With a PCP	Without a PCP	Total No.
Less Than 1 Year	5 (36%)	9 (64%)	14 (23%)
1 to 5 Years	14 (64%)	8 (36%)	22 (35%)
More than 5 Years	23 (88%)	3 (12%)	26 (42%)

My kids have a doctor in Portland. I work in Portland and live in Salem but we are moving back to Portland soon. This is another reason I haven't looked for a doctor here.

I had all our physicals done before moving to Salem (six months ago). I have contacted an OBGYN for my yearly physical and have been accepted as a new patient. I obtained a pediatrician for the children in Salem before we moved here, but they haven't been to see him yet.

A doctor was assigned to them [the children] yesterday. The doctor has a contract through the government foster care program. I just received the children yesterday and needed them to have an exam, a check-up. The doctor couldn't see them in the office so he sent us here [ED]. It is required that they [foster children] have an exam within a couple of days of coming to us. (Three children brought in by foster mother.)

I live in Alaska and work there three months out of the year on fishing boats. I travel the rest of the time.

I've lived in Portland for nine months. Before that I lived in Salem for 20 years. I work in Salem. I did have a physician in Salem but he is retired. I don't have one in Portland.

Have you tried to obtain a primary care provider?

From the interviews I found that 20 (32%) of the patients did not currently have a health care provider. Of these only three (15%) stated they had tried to obtain one. Additional information acquired during the interview process includes: a lack of confidence in primary care providers, a lack of concern in obtaining a primary care provider and difficulty in finding a primary care provider for those new to the area or for those who had just obtained insurance.

I have the OHP and I can't find a doctor to accept me as a patient. I was seen yesterday in the emergency room for an ovarian cyst which they found on ultrasound. The doctor here [ED] referred me to an OBGYN yesterday but the receptionist said that a referral from the emergency room wasn't acceptable to get me in. I went to an urgent care clinic this morning but they refused to see me unless I paid cash because they wouldn't accept the OHP. I went to Salem Hospital's Urgent Care Clinic and they referred me back here to the emergency room.

I called everywhere and can't find one. I have Blue Cross insurance but I still can't find a doctor. (Has lived in Salem three months.)

I've lived here for nine months. I tried the whole phone book. My doctor in Portland has tried to find me one in Salem. I go to Portland every other month to see my doctor there. I have chronic knee problems and no one here will take me. I got hit by a fork lift three years ago while at work. So my medical needs are covered under workman's comp. My wife brings the kids here to the Urgent Care Center. We can't find a doctor for them either. The people at the office where I got the OHP gave me a list of doctors who are supposedly taking new patients. I called about 10 of them and they say they aren't taking new patients.

No. I moved here from Washington last month. I had a medical card there. I couldn't find a doctor to accept it there. It makes me angry that they treat people that way just because they need help to get insurance.

Not yet. I just got insurance at my currant job.

I never have tried to get a doctor for me and the kids. I don't care who sees me or my kids as long as they are good. When I went into labor I didn't care who delivered my kids. Somebody just needed to be there to catch them when they came out. I had prenatal care by a doctor but didn't really care who was there to deliver them.

No. I'm not usually sick enough.

I went to a doctor here in Salem for years. I didn't have confidence in him after a while because he couldn't find things wrong with me. I like coming here [UCC].

I had one but he lost his license about four years ago. I haven't tried to get a new one cause I haven't needed one.

How important is having your own physician or other personal health care provider?

The majority (84%) of those interviewed stated that having a provider was very important. Three (5%) stated it was somewhat important and seven (11%) stated it was not very important. Interestingly, of the 20 people who do not have a physician, 14 answered this question as very important but only two had tried to obtain one. Patients who

responded to this question as very important did not offer an explanation while those who gave other responses, such as not very important, often offered verification for their response.

Having a doctor isn't what is important. Having insurance is.

It's not very important for me because I don't usually go to the doctor. But it's very important for my daughter (2 year old) to have a regular doctor.

Not very important. I trust all equally. I don't really need to have the same doctor every time. I don't have any chronic problems.

I don't see any benefit of going to a regular doctor.

Do you have health care insurance?

Of those interviewed, 34% stated they were covered under the Oregon Health Plan, 19% were uninsured, and 47% had other coverage. There was little fluctuation between the two facilities in types of insurance coverage. The length of time patients had a particular insurance type was often dependent on the length of time they had been employed or qualified for insurance through public assistance. However, not all employers offer health insurance coverage as a benefit. Insurance coverage for children can be particularly complex. For example, in divorced situations in which one parent is mandated to provide insurance for the child, but fails to do so, that child does not qualify for the OHP because that child should have insurance. Another interesting finding was that while certain patients were dissatisfied with care provided under certain types of HMOs, other patients expressed a great deal of satisfaction with these same providers.

Length of time having a particular insurance

We have had this plan for about six years. We were on Medicaid and then went on the OHP. But we were able to stay with.... [HMO].

I will have insurance in about 10 days. It's an HMO program. I had to wait 90 days after starting my job. I will get a doctor after I get insurance and get a list of doctors names.

Health insurance is not a benefit through employer

I don't have insurance. I work for the state as a full-time temp and I don't get benefits.

Until three months ago I had the OHP. I don't qualify anymore because of working. I can't afford it through work. They [work] would pay for half. But for me and my daughter it would cost between \$200 to \$300 a month. I don't work full time (waitress) so I'm going to try to get the OHP again on Monday.

This is covered by workman's comp. I did have health insurance until about seven years ago. I had Blue Cross/Blue Shield through work. Now work doesn't offer it [health insurance].

I'm going to get private insurance early next year. It isn't offered at work. My mom and I just discussed the importance of getting insurance.

My husband works heavy machinery in construction. It is seasonal work with no benefits like health insurance. When he works the pay is good but its only about six months a year so we never qualified for insurance. It is so great that we now have insurance through the OHP. It really helps.

Satisfaction with insurance coverage through an HMO

"I've had the same insurance for 30 years. I've gone through quite a number of doctors over the years but they all work for.... [HMO].

We don't have insurance now. It goes into effect at the end of the month. A job change caused a change of insurance. But we are glad because [HMO] is one type of insurance offered with the new job but we don't want that insurance again. We chose another and will be glad to be back with the doctor we had previously.

I've belonged to this health care group since 1943. I started with them when I worked in their ship yards in Portland during World War II.

We've had it for about five years. We were happy with it [HMO] when we lived in Portland but we don't like it here in Salem. They aren't nice.

We had ...[HMO] in California through work and loved them. We are covered through the OHP under them here and don't care for them... The doctors are odd.

Complexity of insurance coverage for children

My son is covered through the Chemawa Indian Clinic. It only pays for care at their clinic which is not open evenings or on week-ends. His mother also mentioned that his father was supposed to cover him with other insurance and hasn't.

I have the OHP. My two oldest children are covered through their father's insurance. The twins (four months old) are covered under the OHP. My middle child has no coverage. She is supposed to have coverage through her dad but he doesn't have any. The OHP won't cover her because she is supposed to have other coverage.

We have the OHP. But there is new legislation and we might not qualify anymore. I am a student and live off student loans. After next month my daughter and I might not qualify anymore. They [legislators] don't take into consideration older students with families.

I won't be eligible for insurance through work until February (three months). My husband is self-employed and does not have insurance. Our other children (two) are younger than six and are eligible and on the OHP. This child [the patient] was denied the OHP when he turned six. I think it is because my husband and I both work. I was eligible [for the OHP] until two months after my last baby.

On a scale of 1-10 with 10 being life threatening and one being not very serious, something that would probably get better on its own, where would you rate the seriousness of your/the patient's current health problem?

Eighty-two percent from the ED and 83% from UCC rated their/the patient's health problem at five or less on the scale. Interestingly, none of those utilizing the ED/4 FT rated their medical needs above a seven on the scale while four (12%) of those from UCC rated their current health problem greater than a seven. Below is a sample of patient/family comments which provide a broad picture of how they rated the illness/injury and why.

A seven, really about a nine because he is my son." (A two year old with a facial laceration.)

Nine. I think I am pre-stroke. After she was called to the exam area her brother stated that, I'm sure nothing is wrong but she wouldn't settle down until someone convinces her that she is okay. She tends to get somewhat hysterical about things.

Two. Although it could be higher because of my daughter's bleeding disorder. I don't think she broke anything when she fell but she could develop internal bleeding.

One. We were at my father's house and a stray cat scratched her [three year old daughter]. What if it has rabies?

Eight. My son needs a tetanus shot to keep from being life threatening.

A five. They [migraine] won't go away on their own.

Ten. I thought I was going to die last night. I think I have a severe kidney infection.

Normally where can your health care needs be met best?

The majority of patients (76%) described their needs as being met best in a primary health care setting. The second most frequent answer was dependent on where they were currently seeking medical care. Of those interviewed in the ED, 18% stated their health care needs are best met in an emergency department setting, while 15% of those from the UCC described their needs as being met best in an urgent care setting.

Whatever is closest.

Usually in a primary health care setting. It usually is not a big emergency situation. I hadn't planned on spending my Sunday evening in the ER.

An emergency room. It usually is an emergency and we need immediate attention.

In an emergency room. We don't usually go unless it is an emergency. Going to a doctor's office would not be good because keeping appointments is difficult. My husband works and I have to find someone to bring me.

An emergency room because we move a lot and sometimes we get sick when I live away from Seattle.

An emergency room. Appointments are very difficult when you work. I work split shifts and don't always know what my hours will be.

An emergency room. They are more prompt and thorough. They take more time with you here.

An UCC. Normally I don't have health care needs. The migraines are unusual. I would come to the UCC even if I had a regular doctor because I don't know when they will hit.

In an UCC. I'm not usually sick.

An emergency department. They see you right away.

An urgent care clinic. This is where we went before we moved back to Salem two months ago. We used to have [HMO]. It was like having an insurance without having your own doctor. They [the doctors] would come and go. It was aggravating. Under the OHP we picked a different HMO. We didn't want....[HMO] because of our previous experience with them in Salem.

What do you like/do not like about receiving your health care in....setting?

The following comments are responses to the questions of what they like/do not like about receiving health care in a particular setting. Some of the interviewees offered little or no response to these open-ended questions while others were quite willing to discuss the likes and dislikes of the various facilities. One point to remember is that for patients to be included in the questionnaire there needed to be sufficient time to do an interview. Some of the patients commented on the length of time they had to wait to be seen in the ED or UCC. These remarks reflect patients responses from this study and may not be reflective of the patients excluded from the study because of their shorter waiting period.

What do you like about receiving care in an office setting?

I like the personal feel you get when you have a regular doctor.

Never have been to one except for immunizations as a child. I've never been ill. (22 year old)

It is more comfortable. We have more time to talk to the doctor. It is more private.

More one on one.

They know me. They can look at the whole picture because they know my history.

I am satisfied with the pediatrician at.... [HMO]. But in general I don't like the others [doctors].

I get to see same doctor that I know and trust.

Nothing! They make you wait to have an appointment and then make you wait there. I don't care for it.

What don't you like about receiving your care in a private office?

The office hours are only nine to five, Monday through Friday. They should expand their hours.

Takes you too much time to get in.

You have to go through too many people. You have to re-explain over and over.

The cost. They tend to find things or look for more things wrong. They don't listen to you.

What do you like about receiving your care in an ED?

I can't afford to go to a regular doctor because I don't have insurance. The emergency room can't turn you away.

In the emergency room the staff shows they care about you. Receptionists are really rude in doctors offices.

What don't like about receiving your care in the ED?

I don't like waiting in the emergency room because of all those really sick people."

I don't like being exposed to people that you don't know and who have unknown illness. They cough all over you.

People here [ED] are probably sick and I don't want to get anything from them.

I don't like the emergency room. It's too time consuming.

What do you like about receiving care in UCC?

I wanted to be seen today.

I like going to urgent care clinics because you can get in the same day that you need it.

It's urgent. You don't have to wait very long.

I didn't need an appointment and can use it on my schedule.

I like coming to the emergency room and Urgent Care Clinic because they are within walking distance of home. I like the Urgent Care Clinic because it is cheaper, quicker, and more family oriented than the emergency room. I like the emergency room because they take care of our emergencies. They also have specialists.

I don't have to wait days for service. I can be seen the same day. The doctors treat me good here.

The convenience of not making an appointment.

I don't have to make an appointment and take time off work.

How long have you had your current illness or injury?

Length of time having their current illness or injury is one area on the questionnaire where interview responses from the two facilities were quite different. Of those utilizing the ED/4FT, 53% of the patients stated they had their current illness/injury one day or less. (Thirty-two percent stated the duration was less than six hours.) In contrast, of those utilizing the UCC, 77% complained that they had their current illness/injury for at least two days. Also notable is that three of the patients from the 4FT area were not being seen for an illness or injury but for a mandatory physical exam. These foster children appeared healthy and the foster-mother had not noted any sign of physical illness. Patient responses below are from patients being interviewed in the UCC. These provide some insight into why a person would feel the need to be seen today even though they may have had their medical symptoms for a few days. People appeared to come to the UCC when either their symptoms had become increasingly more uncomfortable or when they were just tired of feeling bad.

Over a week. I had the flu and that went into a sinus infection. It is painful now.

Two days. I have cold symptoms. I'm such a baby. They will just pat my hand, but that's ok. I need someone to tell me I'll be ok.

We have had the flu and colds for three weeks off and on.

I've had a chest cold for three days and I want a prescription for an antibiotic.

It started about a month ago. I have a bad back that was hurting and then my leg and foot started hurting. I've had a fever, sinus problems and sore throat this week.

I've had this for two weeks. The cough is getting worse. I coughed all night. I'm tired of this and I have to go to work tomorrow.

Four days with a cold. But tonight she started pulling on her ear and screaming. This was after the office closed tonight. (13 month old child)

My son has asthma. Until a year ago I didn't have good luck with my son's doctors through[HMO]. They always told me he had a cold. I knew he had asthma. His grandfather does. His new doctor has put him on medication that really works. He usually spends 10 to 15 days a year in the hospital. His asthma got bad. With the new doctor he has had no hospitalizations. It has made a big difference.

How do you view your own/the patient's general health?

Ninety-three percent of the patients from the ED/4FT interviews and 82% from UCC interviews perceived their health status as good. None of the interviewees perceived their/the patient's health as poor. Two of the patients from the ED and two from the UCC mentioned having chronic problems. These problems included asthma, cancer, a knee injury, and one patient had stated that he was disabled. Three of these patients stated that their general health was fair. The man who shared with me that he was being treated for cancer stated that his general health was good. He also added the comment, "My body gives out on me sometimes though".

In general, when is the most convenient time for you to receive your health care?

Forty-one percent of those responding to this question stated that during the day, especially the morning, was best. For 20% of the patients, the afternoon was the best time to receive their health care. Thirty-one percent preferred evenings or week-ends and 8% said that anytime was good for them. This suggests that the limited office hours offered by many primary care providers may not be a major factor in choosing to seek care in the UCC or ED.

What are the main reasons you chose the ER/UCC for medical care today instead of some other place?

Responses to the question of why patients chose to use the ED or UCC are very informative. The most frequently given answer was that when they had telephoned or went

to the office of their primary care provider they were instructed - usually by the office staff - to go to the ED or UCC to receive care. (See Figure 6 - Main Reasons for Choosing to Use the ED/UCC) An employee from the UCC indicated that this is not unusual. "When the provider just can't see anymore patients because of an already booked office schedule they either have to ask the patient to wait or send them to us. We help take care of their overflow. It really works out well for them because they don't have to hire another provider for their office and pay for extra overhead expenses." Because of the time of day in which most interviews occurred - during the evenings and weekends - it is possible that these numbers also reflect times when the offices of providers were closing for the evening or were not open for patient appointments on weekends. Of interest is that only 18% of those using the ED expressed that their reason for using the facility was because they felt it was an emergency. Below are samples of patient responses obtained during the interview process. These include comments about being referred, those who had obtained a recommendation by a pharmacist or employers, the cost of receiving care, and that the condition was an emergency.

Table 6 Main Reason for Choosing to Use ED/UCC

Reason for Use	ED	UCC
Referred by primary provider/office staff	11(39%)	16(46%)
Convenient/Open	6(21%)	5(15%)
No provider	4(14%)	6(18%)
It is an emergency	5(18%)	0 (0%)
Recommended by friend or employer	1(4%)	4(13%)
Less expensive	0 (0%)	2(6%)
From out of town	1(4%)	1(3%)

Referred

I tried to call the advice nurse. I was put on hold for too long and hung up. In the phone book under our insurance it said we could come to Salem Hospitals' Urgent Care Clinic.

I prefer going to our regular doctor. As a mother I understand the needs of my family and can make appointments or obtain phone advice when I need to. I usually can get in to see her [doctor] but couldn't today. I think I broke a bone in my foot and so they [doctor's office] told me to come here. But I don't like it here [ED]. Other people are much sicker and need to be here. I would have rather gone to my own doctor.

I went to [HMO] without calling because I knew that she [daughter] would need to be seen right away. They [HMO] couldn't see her today so they sent us to the Urgent Care Clinic. She needs to have back and neck x-rays so they [UCC] sent us to the ED. Now we have been sent to fast track. Between.... [HMO] and fast track it has been three hours and we haven't had dinner. She [daughter] is getting real hungry but she can't eat until the x-rays are done.

Initially I took her [daughter] to the Pediatric Clinic after birth and for immunizations. Then I took her to Salud in Woodburn. I received my prenatal care through them. Salud is very good, especially the doctors there. We are covered under the OHP and they [the State] said we should go to a different clinic. I have never been to this clinic. I tried to call them last week but couldn't get through. The line was busy. Yesterday, after work, I took her [10 month old daughter] there but it was 5 PM and they were closed. Today I just went there and they couldn't see her so they sent me here.

The doctor on call told me to come to the Urgent Care Clinic. I don't know him at all and he doesn't know me. I would probably rather have gone to the ED.

His father works in Portland but lives here. Their insurance won't cover Salem doctors. My daughter contacted her [the child's] doctor in Portland and he okayed the Urgent Care visit. (Interviewed the grandmother of six month old child)

Recommended

My son comes to visit me on the weekends. His mother dropped him off tonight and his face, especially around his eyes, is covered with poison oak. I called a pharmacist and was told that he [son] needed to be seen right away. I called the emergency room to decide if we should go to the urgent care clinic. The person I talked to said to come here to the emergency room.

My work [employer] sent me here. I would have preferred going to my own doctor but my work said it is cheaper to come here.

Work [employer] suggested I come here [UCC] because it is on the way back from where we were working when I got hurt. I didn't want to go to the emergency room. I would get in the way of people who have more life threatening problems.

Less expensive

We have been here before. It is less expensive than an emergency room. If it was during the day I would have called my previous doctor even though my insurance will not cover it until the end of the month. I have confidence in him.

My daughter (three years old) has a rash that has to be seen before going to day care on Monday. I know she has ring worm from our new kitten. I am already being treated for it but was concerned that my medication would be too strong to put on her..... I have to meet a deductible before her [daughter's] insurance pays. It is as cheap to come here as going to the doctors office.

Emergency

I prefer taking my son to his regular physician because he knows him and cares about him. I came here [ED] today because it is a more pressing situation. His regular doctor might not be able to handle it. (Three year old child put a bead in his nose.)

During the interview process I found that approximately three-fourths of the patients who lived in the Salem-Keizer area had a primary care provider but that not all patients had a good relationship with their provider. Of those who lacked a primary care provider, many had recently moved and/or lacked health care insurance and found this a barrier to obtaining a provider. Others believed themselves to be in good health and felt there was no urgency in obtaining a provider. The interviews also provided useful information on patient's perceived health status in general, as well as their perception of the severity of their current illness/injury. None of the patients felt they were generally in poor health and most did not feel their current problem was life-threatening. Most of the patients rated their symptoms as somewhat minor. Some of the patients offered further explanation in that their condition, although minor, could become a life-threatening problem without proper medical treatment. Of the patients who reported

having a primary care provider, 64% had been referred to the ED/UCC by their primary care provider or office staff. Although this finding cannot be generalized to the total population who use the facilities for nonemergent needs because the sampling was done primarily in the evening and weekends, it might be representative of those who use it during these times.

CHAPTER 5

DISCUSSION

Emergency Departments provide access to care for large numbers of patients who have nonemergent medical needs. From June 1, 1994, through May 31, 1995, approximately 60% of the patients presenting to the ED at Salem Hospital (Salem, Oregon) were triaged as nonemergent (4 or 4-FT). In February of 1995, in an effort to provide an alternative location for receiving nonemergent medical attention, the hospital opened an Urgent Care Center a few blocks from the ED. The purpose of this study was to determine who uses the emergency department at Salem Hospital and why, and what effect the Urgent Care Center had on providing an alternative to the emergency department. My anthropological methodology uses both quantitative and qualitative techniques. Included in the study is a random retrospective chart review of 462 patients who utilized the ED and 183 patients who utilized the UCC. The collected data were analyzed and compared with information found in the literature review. I completed interviews with hospital staff and with patients and/or their families and integrated these responses into the analysis. My own experience as a nurse allowed me to offer some amount of interpretation in the final discussion and perhaps a more balanced picture of the findings.

Summary of Major Findings

Age and gender in the sample groups did not differ from information found in the literature. There were almost equal numbers of males and females, and those under the age of 40 utilized the ED and the UCC more often for nonemergent needs. Loneliness, as an indicator of ED utilization, was difficult to assess since information recorded in the hospital charts does not go beyond the classification of marital status. During the interview process I found that most patients did have social networks, but these networks may have included people who were not related.

Findings in the literature suggest that insurance coverage and access to a primary care provider are strongly associated with ED use. Those on public assistance and the uninsured are more likely to use the ED as their regular source of care. My research shows that over 60% of those on the OHP/Medicaid listed a provider, while only about 25% of the uninsured listed a provider. Comparatively, 70% of those with other types of insurance listed a primary care provider. One reason for the rather high percentage of those on the OHP listing a provider is that many of these are assigned a provider when they choose their HMO insurance type. Being assigned a provider does not necessarily indicate that the person has actually contacted that provider, only that one has been assigned.

It is beyond the scope of this research to speculate on the number of patients who are on the OHP but utilize the ED and/or the UCC as their regular source of care, but the number of patients involved may be significant. This may also be true of other HMO insurance programs offered through employment which require individuals to choose a provider from an approved list. Findings from patient interviews show that 71% of those utilizing the ED and 65% of those from the UCC stated they had a primary care provider. Of these, 60% of the ED and 41% of the UCC patients had not been to their own provider over the last four months but had utilized the ED or UCC at least once.

During patient interviews I found that 68% of the patients stated they had a primary care provider and that 64% of these had been referred to the ED or UCC by their provider or, more often, by office personnel. Although the majority of patients were interviewed in the evenings and on weekends, many of them began having symptoms during normal office hours. Interviews with the ED and UCC population indicated a number of personal preferences regarding care in these settings as compared with a primary care setting. For instance, a number of patients indicated a preference for a problem-focused physician interaction that did not research into details of health and lifestyle unrelated to the current problem. Conversely, a number of other ED and UCC patients whose care usually comes in a primary care setting indicated strongly that they would have preferred seeing their primary care provider for their problems and have their care delivered within a setting of consideration for overall health management. On an observational level, however, I found that there was also a large segment of the ED population who claimed not to want a problem-focused physician yet were very eager to discuss not only the details of the current

problem but multiple aspects of previous health care and life in general, sometimes at great length. A number of patients seen in the ED seemed disappointed when their interview came to an end and appeared to have additional information, which they would have been pleased to discuss.

The literature indicates that need factors such as the presence of chronic health conditions or a patient's perception of their own health may influence emergency department utilization. Furthermore, psychosocial stressors may have the most influential impact on ED use. Findings from the two chart samples show that there were slightly more patients who had complaints of illness than injury. However, the percentage of those in categories based on diagnosis differed between the facilities. This may indicate that patients choose to go to one or the other of the facilities based on their perception of the severity of the problem. Findings from patient interviews suggest that the majority of patients did not believe their condition to be life threatening, and in most cases, considered their condition to be somewhat minor. The decision by patients (or parents of pediatric patients) of which facility to visit may be influenced by the time from the onset of their symptom to the time they choose to obtain care. From the interviews it was found that the majority of patients (53%) who went to the ED had had their current illness or injury less than one day while 77% of those interviewed in the UCC had had their symptoms for at least two days. There is an apparent difference in time from onset of symptoms and presentation for evaluation between those using the ED and UCC. This may reflect a difference in the medical type of problem, although the ED care group may also be exhibiting less patience in a persistent symptomatic state before seeking aid.

The majority of patients who used both the ED and the UCC had only one visit during the year. However, a small number of patients accounted for an excessive amount of all visits during the year by virtue of repeat visits. Multiple users, those who used the ED or UCC more than five times during the year, differed from the total population in many respects. There was a higher percentage of multiple users from the ED sample who were covered by the OHP/Medicaid and who listed a primary care provider than from the total ED population. Of the multiple users in the UCC sample, there were more uninsured and fewer who listed a provider than those of the general UCC population. In both groups, the percentage of adults not employed was higher than in the total sample populations.

Multiple users from both facilities differed in diagnosis as compared to the general population. Especially noteworthy is that the percentage of psychiatric related diagnosis was higher in the ED multiple user group and that two of the multiple users from the UCC population were treated for an infection directly related to IV drug injection. This correlates with information found in the literature in that multiple users may have more psycho-social problems than the general population. Multiple users may be less able to utilize a primary care provider effectively. Calling for an appointment, waiting for an appointment, and being in an environment (office setting) where they feel uneasy, may contribute to certain patients choosing to go to an emergency room or urgent care center and to avoid a private office setting.

Numerous observations of single users provided a sidelight on patterns of ED usage. One difference between the ED and UCC populations was the larger number of patients presenting in the ED for evaluation with complaints but without identifiable diagnoses. Cases of dizziness, fainting, shortness of breath, and other complaints were all evaluated in the ED without identifiable medical causes being found. Some, or all, of these patients may have had medical problems not apparent to the ED examiner, but I found no patients in the UCC sample in which they presented with symptoms for which a medical reason could not be found. There were also a number of ED cases for whom secondary gain in presenting to the ED might have been a consideration. For example, included in this group was a patient who complained of shortness of breath after being chased by the police. Among the ED cases for whom no medical diagnosis was made, it is interesting to note that emotional stress was mentioned in the physician's evaluation. Perhaps equally interesting is that a diagnosis relating to the patient's emotional state was nevertheless not made. Reticence, either institutional or professional, to advance a psychiatric diagnosis in the ED setting should perhaps be considered. Hesitation in making a diagnosis relating to substance abuse is also a possibility. For instance, one patient who presented in the ED with complaints of "bugs jumping and burrowing into her skin" was evaluated, found to be without medical causes for this problem, and was signed out of the ED with a diagnosis consisting of a restatement of her presenting complaint. Reviewing the case with an ED physician, possibilities of substance abuse or psychiatric illness seemed suggested by the presentation. However, the importance of avoiding diagnoses with such potentially negative

ramifications for the patient without incontrovertible documentation and (preferably) subspecialty consultation is equally apparent.

Presentation of my data in the selection of diagnoses groups must also reflect the judgement of the ED staff documenting the visit. For instance, in the "skin" diagnosis, there were 18 patients with cellulitis/infection. This group includes a patient with a superficial infection of a self-inflicted genital laceration which the patient explained as an attempted circumcision performed while intoxicated. However, a component of depression and self-destructive behavior was also considered in the ED record of the case. Accordingly, the patient might have been classified as a laceration, psychiatric illness, or a category of substance abuse. Numerous cases might have fit into such a group, although the recorded diagnosis virtually never referred to problems of this nature.

Discussion with the ED staff prior to the opening of the UCC is also important when looking at the data presented above. Based on their experience, the staff was concerned with the decision to close fast track. It was evident to them that there was a large population for whom the UCC would not be an option, regardless of their nonemergent medical status. More than half (53%) of the patients in the UCC sample had not used the ED at Salem Hospital during the two year period (June 1, 94, through May of 96) for which data were collected. Eleven percent of the sample used the ED during the first year but used the UCC exclusively during the second year. Interestingly, 35% used both facilities. Of those in the UCC sample, 9% had initially presented to the ED for care on the date in which they became part of the sample population. Although the UCC sees approximately 2,000 patients a month, the number of patients with a triage number of 4 and 4-FT seen in the ED at Salem Hospital declined by less than 10% in the seven months following its opening.

Findings from my research show that the Urgent Care Clinic provides an alternative source of health care to the emergency department for many people in the community including some who use the facility many times a year. As might be expected, it is particularly beneficial to those whose usual source of care is unavailable, those who typically are healthy and have an occasional non-chronic medical need, and for those who are unable to find a primary care giver who will accept them. However, many ED users appear to choose their place of medical care for reasons that reflect a variety of other personal or

social needs. Many of these patients have problems that are not easily addressed through the provision of medical care alone and need social assistance more readily available through the ED. Some of these patients have moderate psychiatric dysfunction and/or addiction problems or homelessness as well as underlying medical problems. Some of the patients who visit the ED prefer to have care from a physician with whom they do not have a former relationship or plan to have one in the future; in other words they wish to feel as anonymous as possible. Such situations may limit patients' ability to obtain care in a regular office setting and may also make them undesirable patients and beyond the scope of care in which many providers feel comfortable. In some cases, past experience has affected their trust in the primary care system and they feel secure that the ED provides them with their best option in receiving care.

Perhaps the lesson to be drawn from these findings is that the classical medical model of care, in which a primary provider supervises a continuum of care services, fails to meet the needs or expectations of a patient population which has already identified itself by seeking care through a series of ED visits. For planners of health care programs, the existence of this group of patients may represent a segment of the health care consumer population for whose needs adequate planning has not as yet been addressed. Lacking a justification (not to mention, lacking a means) to coerce this population into the traditional health care world, it may be necessary to provide for these patients by aiming to most efficiently provide them with the full range of services they need in the care setting they have clearly chosen - hospital emergency departments.

Study Limitations

Caution is advised in making inferences to a study, such as this, in which the population of only one hospital and urgent care clinic are included. However, this information is useful when looking at utilization patterns and factors pertaining to those who receive their care outside of a primary care setting.

Recommendations and Future Research

Recommendations for further research include:

1. A further examination of additional social demographic characteristics of those who utilize the ED and UCC such as educational status, income, and family-structure.
2. A study of the multiple user population (those who use the ED and/or the UCC more than five times during the year) through personal interviews.
3. An examination of the association between ED users with psychiatric problems, availability of alternative mental health services and ED use.
4. A random study of patient compliance on those instructed by ED staff to obtain a follow-up visit with their own provider or with the physician on ED back-up.
5. A study of managed care patients who use the ED and UCC in comparison to visiting their approved provider.

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APPENDICES

APPENDIX AINFORMED CONSENT DOCUMENT

My name is Cathy Stiles. I am a graduate student at Oregon State University in the Department of Anthropology. I am currently working on my thesis which is about access to health care and the use of the Emergency Room and Urgent Care Clinic. As part of my work I have developed a questionnaire. I believe that information obtained directly from the people who use these facilities can provide valuable information in making positive changes in the provision of health care in our community. Although Salem Hospital has given me permission to do my research here, I need to assure you that your care will not be affected by your choosing to participate or not in my research project. If you agree to participate. I will not ask for your name nor will I ask about your medical condition. Also, you may choose to answer only those questions you wish.

Would you agree to participate in my questionnaire?

Are you at least 18 years of age?

APPENDIX B

ED/FAST TRACK/URGENT CARE QUESTIONNAIRE

- 1.) Which person in the group is being seen for health care?
Adult - male female Child - male female
 - 2.) Person interviewed.
Patient Mother Father Other
 - 3.) Number in group.
 - 4.) What is your marital status? M D S W
 - 5.) In what town do you live?
*The patient?
 - 6.) How long have you lived here/there?
 - 7.) What is your date of birth?
*What is the age of the patient?
 - 8.) Do you currently have a regular physician or other health care provider?
Yes No
If yes to above
How long have you had this health care provider?
*Does the patient?
- Did you contact your own physician (provider) prior to coming to the ED/UCC?
- If No to above
Have you ever had one in this area?
- Have you tried to obtain one in Salem (your town)?
- 9.) Is having your own physician or other personal health care provider:
Very important Somewhat important Not very important
 - 10.) When you were a child where did you primarily receive your health care?
PP Health Clinic ED Other
 - 11.) Do you have health care insurance?
Yes No
*Does the child?

- 12.) What type of health insurance do you have?
BC Group Medicaid OHP Auto Workman-comp Medicare Kaiser HMO
*The patient?
- 13.) How long have you had this particular health care plan? Or- Have you ever had health care insurance?
- 14.) How do you view your own general health? Good Fair Poor
*The patient?
- 15.) How long have you/they had this current illness or injury?
- 16.) How many times over the last year have you stayed in the hospital overnight for health conditions?
*The patient?
- 17.) How many times over the last 4 months have you received health care treatment in an Emergency Room? -
Urgent Care Clinic? -
Private Physicians office? -
*The patient?
- 18.) Normally where can your health care needs be met best?
A PHC setting An UCC An ER Other Setting
- 19.) In general, when is the most convenient time for you to obtain you health care?
Why?
- 20.) On a scale of 1-10 with 10 being life threatening and 1 being not very serious, something that would probably get better on its' own, where would you rate the seriousness of your/the patient's current health problem?
- 21.) What do you like about receiving your health care in the ER/UCC?
What don't you like about it?
- 22.) What do you like about receiving your care in an office setting?
What don't you like about it?
- 23.) What are the main reasons you chose the ER/UCC for medical care today instead of some other place?

Observations:

Ethnic Identity – W H B A O

Date _____ Time _____ Day of the week _____

Length of interview _____

Interview Area - ED FT URG

Other comments or observations

APPENDIX C

Emergency Department Diagnosis

Cardiopulmonary		Lacerations	
Bronchitis	10	Laceration	58
Mild Congestive Heart Failure	3	Suture Removal	11
Pneumonia	2	Puncture Wound	6
Asthma	1	Dog Bite	4
	Total 16	Human Bite	3
			Total 82
Central Nervous System		Viral Syndrome/Chicken Pox	
Head Ache/Migraine	13	Viral Syndrome	11
Paresthesia	1	Chicken Pox	2
Tic Doloroux	1		
	Total 15		Total 13
Eye, Ear, Nose, and Throat		Gastrointestinal	
Otitis Media	13	Acute Abdominal Pain	8
Pharyngitis	8	Gastroenteritis/Gastritis	8
Corneal Abrasion	5	Constipation	2
Sinusitis	4	Hernia	2
Tonsillitis	4	Spastic/Irritable Colon	2
Otitis External	2	Hepatitis	2
Upper Respiratory Tract Infection	2	Hemorrhoids	2
Cerumen (Ear Wax)	2	Peptic Ulcer Disease	2
Foreign Body In Nose (candy, foil)	2	Biliary Colic/Colic	2
Sore Throat	2	Diarrhea	1
Allergic Conjunctivitis	1	Esophagitis	1
Peritonsillar Abscess	1	Diverticulitis	1
Hematoma of Auricle	1	Anal Fissure	1
Foreign Object in Eye	1	Abdominal Mass	1
Stomatitis	1		Total 37
	Total 49		
OBGYN		Urology	
Possible Ovarian Cyst	3	Urinary Tract Infection	15
Spontaneous Incomplete Abortion	2	Nephrolithiasis	2
Mastitis	2	Epididymitis	1
Pregnant	2	Gonorrhea	1
Possible Ectopic Pregnancy	1	Pelvic Inflammatory Disease	1
	Total 10	Stress Incontinence	1
			Total 21

Skin	
Cellulitis/Infection	18
Abcess	4
Herpes Zoster (Shingles)	3
Contact Dermatitis (Poison Oak)	2
Viral Exanthem	2
Ulceration	2
Rash	1
Scabies	1
Dyshidrosis	1
Burn, 2 nd Degree (Sun)	1
Total	35

Psychiatric	
County Mental Health Evaluation	5
Psychiatric Disorder	2
Suicidal	2
Exacerbation of Schizophrenia	1
Anxiety/Depression	1
Total	11

Fractures	
Fractures	9
Total	9

Miscellaneous	
Well Exam/Nothing Found	15
Dental	10
Left Without Being Seen	9
Requests	8
HMO Denied	6
Hair Conditioner Ingestion	1
Lithium Toxicity	1
Total	50

Musculoskeletal	
Sprains and Strains	53
Dislocation	5
Low Back Pain	4
Chest Wall Pain	2
Tendonitis	2
Torticollis	2
Muscle Tear	2
Traumatic Joint Disorder	1
Ganglion Cyst	1
TMJ Syndrome	1
Carpal Tunnel Syndrome	1
Degenerative Joint Disease	1
Gout	1
Total	76

Superficial Trauma	
Contusions/Abrasions	36
Hematoma	2
Total	38

Urgency Care Clinic Diagnosis

Cardiopulmonary		Lacerations	
Bronchitis	3	Laceration	7
Hypertension	2	Puncture Wound	7
	Total	Suture Removal	6
			Total
			20
Central Nervous System		Viral Syndrome/Chicken Pox	
Headache/Migraine	7	Viral Syndrome	1
	Total		Total
			1
Eye, Ear, Nose and Throat		Gastrointestinal	
Otitis Media	15	Gastritis/Gastroenteritis	6
Pharyngitis	7	Possible Cholecystitis	1
Allergic Rhinitis	5	Mesenteric Lymphadenitis	1
Upper Respiratory Tract Infection	4	Hemorrhoids	1
Corneal Abrasion	4		Total
Conjunctivitis	2		9
Tonsillitis	2	Urology	
Sinusitis	1	Urinary Tract Infection	2
Eustachian Tube Dysfunction	1	Hematospermia	1
Foreign Body in Eye	1	Possible Kidney Stone	1
Mononucleosis	1		Total
Thrush	1		4
	Total		
	43	Musculoskeletal	
Obgyn		Strains and Sprains	17
Pregnant	1	Tendonitis	5
Vaginosis	1	Low Back Pain	4
Abcess of Labia	1	Scapulocostochondritis	1
	Total	Chronic Shoulder Pain	1
			Total
			28
Fractures		Superficial Trauma	
Fractures	4	Contusion/Abrasion	9
	Total	Hematoma	1
			Total
			10
Skin		Miscellaneous	
Cellulitis/Infection	14	Rule Out Meningitis / Malaria	1
Contact Dermatitis (Poison Oak)	4	Dental	4
Burn, 2 nd Degree	3	HMO Denied	1
Abcess	2	Requests	7
Viral Exanthem	2	Left Without Being Seen	1
Shingles	1		Total
Paronychia	1		14
Folliculitis	1		
Ecthyma	1		

Drug Eruption (Drug reaction)	1
Furuncle	1
Herpetic Vitlow	1
Total	32