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PATIENT AND PROVIDER PERCEPTIONS OF WHY PATIENTS SEEK CARE IN EMERGENCY DEPARTMENTS

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☐ **Abstract—Background: Little is known about why patients choose emergency departments (EDs) to receive care. Objective: Our aim was to measure the distribution and frequency of the stated reasons why patients choose the ED for care and why primary care physicians (PCPs) think their patients utilize the ED. Methods: The authors conducted a survey of patients presenting to an ED with 92,000 annual visits. Appropriate parametric tests were used for univariate and multivariate analysis and results were presented as frequencies with 95% confidence intervals. The authors also performed a cross-sectional survey of PCPs through a web-based survey. Results: Of the 1515 patients approached, 1083 (71%) agreed to participate and 1062 (98%) of them completed the survey. The most common reason patients gave for coming to the ED was their belief that their problem was serious (61%), followed by being referred (35%). In addition, 48% came at the advice of a provider, family member, or friend. By self-report, 354 (33%) patients attempted to reach their PCPs and 306 (86%) of them were successful. Two hundred and seventy-five PCPs were also surveyed. The most frequent reasons PCPs thought their patients came to an ED were that the patient chose to go on their own (80%) and the patients felt that they were too sick to be seen in the PCP's office (80%). Conclusions: The majority of patients stated that the most common reason for seeking care in an ED was that they thought their problem was serious. Almost half sought ED care on the advice of a family member, friend, or health care provider, and a sizable minority were actually referred in by a health care provider. PCPs agree that most patients come to EDs because they believe they are too sick to be seen in their office or become sick after office hours.** © **2014 Elsevier Inc.**

☐ **Keywords—emergency department; utilization; overcrowding; health-care–seeking behavior; referral**

INTRODUCTION

In 2007, according to the Centers for Disease Control and Prevention (CDC; cdc.gov), there were 117 million visits to emergency departments (EDs) across the United States (1). This represents an increase of 1 million visits since 2005 (1). This trend has been largely ascribed to the growing number of medically uninsured individuals (2). However, in Massachusetts, despite near-universal health care, ED visits continue to rise, suggesting that access and constraints on provider capacity, rather than insurance status, serve as the key drivers of ED use (3). Given the national shortage of primary care providers (PCPs), the Massachusetts experience may predict ED use nationwide if the universal health insurance provisions of the recent health care reform law go into effect (4).

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Impacted by progressive increases in patient volume, ED crowding continues to be a significant issue. In a 2006 survey of medical directors, 90% of hospital directors reported ED crowding, suggesting that ED crowding is a problem in virtually every state (5). In addition to long waits and the frustration of personnel and patients, ED crowding also leads to a greater risk of poor health outcomes (6). For instance, treatment wait times have been found to be longer for pneumonia patients in crowded EDs (7).

In summary, ED volume continues to rise and contributes to ED overcrowding, but very few studies have attempted to measure the patients' perspectives on why they chose the ED to receive their medical care. Even less is known about whether patients had been referred to the ED by a PCP and, if so, why. The study objective was to measure the distribution and frequency of the stated reasons why patients chose the ED for their care. A secondary goal was to measure the distribution and frequency of the reasons why PCPs thought their patients utilized the ED.

METHODS

Study Design

We simultaneously conducted a cross-sectional survey of patients presenting to an ED with 92,000 annual visits and a survey of PCPs practicing in the same urban academic medical center. The local Institutional Review Board approved this study.

Patient Survey

Study setting. This study took place in the ED of an urban academic medical center staffed by board-certified or board-eligible emergency medicine (EM) faculty, supervising EM and other residents. Providers were unaware of a patient's insurance status when making disposition decisions. They routinely discussed admission decisions with a referring physician or a PCP, if one was identified by the patient or in the medical record. The study was performed between July and August of 2009.

Study population. Patients seen in all areas of the ED (including pediatrics and psychiatry) were deemed eligible to participate in the study. We excluded patients who were too ill medically or psychiatrically to complete the survey. Prisoners, persons under arrest, and sexual assault victims were excluded from the study, as were patients participating in other research protocols. For psychiatric and acutely ill patients, appropriateness to be interviewed was determined by their attending emergency physician. Parents of pediatric patients were interviewed.

Physician Survey

Study population. We surveyed all PCPs of patients who sought care in our ED at least once during the previous year. The roster of physicians was obtained from the ED medical information system for patients who were seen in the ED from May 2008 to May 2009. As PCP status was assigned to each physician by their patients, the sample included PCPs (adult and pediatric) as well as medical specialists. All surveyed physicians were members of the academic medical center at which this study took place.

Measurements

Patient survey. The primary outcome was the distribution of responses to closed-ended survey questions on why subjects chose to come to the ED for their care. The secondary outcomes were the frequency and 95% confidence intervals (CIs) for the percent of patients who attempted to reach their PCP or other provider and the distribution of the results of these attempts. We also measured the difference in hospital admission rates between patients referred in by providers vs. those who were not, and whether this referral status, the patient's age or sex were associated with the probability of an inpatient admission.

To create the survey, we searched to identify evidence-based data on this topic. Having discovered no standardized, validated survey to use, we incorporated data elements from similar prior surveys. The principal author and senior author then revised this questionnaire for grammar and consistency with input from all coauthors. We then reviewed the survey with non-coauthor ED providers for clarity and further revised it based on feedback. Finally, we tested the survey on five ED patients (not included in our study population) to confirm clarity and internal consistency. This survey was conducted 24 h per day, 7 days per week in randomly selected time blocks. PCP status was defined as known PCP, unknown PCP, and no PCP as reported by patient at ED registration and obtained from the institution's registration database. Insurance status was defined as private insurance, Medicare, Medicaid, other (e.g., workers compensation, international insurance), or self-pay (which was presumed to imply no health insurance). Disposition status was obtained from the ED medical information system and included the following categories: admitted to the hospital or ED observation unit; treated and released; left without being seen; left without completing treatment; psychiatric facility transfer; or left against medical advice. Off hours were defined as Saturdays, Sundays, and 5:00 pm to 9:00 am on weekdays.

Physician survey. The primary outcome of the physician survey was the distribution and frequency of the reasons why PCPs thought their patients utilized the ED. The