Why Parents Seek Care for Acute Illness in the Clinic or the ED: The Role of Health Literacy

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Abstract

Objective: To explore the decision to seek care and decision-making regarding location of care among parents with low and adequate health literacy.

Methods: Parents of children 8 years old or younger who presented for 'sick child' visits at a clinic or a nonurgent emergency department (ED) visit (triage level 5) were interviewed. The Newest Vital Sign was used to categorize parental health literacy. Interviewers followed a semistructured interview guide to understand: 1) care-seeking for current illness, and 2) choice of clinic or ED. Themes emerged using a grounded theory process, facilitated by NVivo version 10.0 software (QSR International, Melbourne, Australia). Themes included the experiences of low and adequate health literacy in the clinic as well as in the ED.

Results: Fifty semistructured interviews were completed with parents who brought their child to the ED for a nonurgent visit (n = 30) and clinic parents (n = 20) with 56% possessing low health literacy. Parents with low health literacy were more inclined to overestimate severity of illness and seek care sooner to gain answers about the illness and treatment options, and visit the clinic only when an appointment was available within hours. Parents with adequate health literacy sought reassurance for their ongoing illness management and valued close relationships with their physician, and were willing to wait longer for an appointment. Fever, vomiting, and young child age prompted some parents to seek expedient care regardless of health literacy.

Conclusions: Caregiving skills (eg, assessing and treating illness, understanding illness severity, and navigating the health care system) in addition to physician-parent relationships and perception of care seem to influence the behavior of parents managing their child's mild acute illness. These factors might be amenable to a future health literacy intervention.

Keywords: child; emergency service; hospital; health literacy; health services accessibility; utilization

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What's New

Health literacy-related caregiving skills seem to influence parents' behavior when managing their child's mild acute illness. Assessing and treating illness, understanding illness severity, and navigating the health care system are skills that might be amenable to a future health literacy intervention.

More than half of parents who present to the emergency department (ED) with their children have low health literacy, which affects their ability to make health decisions for their child.[1,2] Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[2] Low health literacy is independently associated with increased preventable ED visits and hospitalizations with an estimated cost >$200 billion annually.[1,3,4] Adults with low health literacy exhibit negative health behaviors that affect child health, such as inaccurate medication dosing.[3,5] Parental low health literacy is also associated with increased child nonurgent ED use.[1,6]

More than half of the 20 million pediatric ED visits in the United States annually are nonurgent.[7,8] Nonurgent illnesses common in pediatric ED visits include acute illnesses such as viral upper respiratory infection, viral gastroenteritis, or fever.[9,10] In addition to low health literacy, nonurgent ED use in children has been associated with low socioeconomic status, lower educational attainment, factors related to quality of primary care, and limited ability of parents to accurately judge the urgency of the condition.[1,6–9,11–15] Although there is an increase in nonurgent pediatric ED use by parents with low health literacy, some parents with low health literacy access their primary care providers for same-day sick child visits. Reasons for choosing the clinic versus ED are not well understood. We sought to gain the perspective of parents in the clinic as well as in the ED to understand the care-seeking behavior for nonurgent

acute pediatric illness that occurs in both locations. To our knowledge, no previous research has qualitatively examined reasons for seeking care in the ED as well as clinic settings, nor has it examined health literacy to further understand care-seeking behavior.

In this qualitative study of parents who sought nonurgent care in the ED and a demographically similar clinic we sought to explore differences in seeking care and decision-making regarding location of care among parents with low and adequate health literacy.

METHODS

DESIGN AND POPULATION

We conducted individual semistructured interviews with a purposive sample of English-speaking parents aged 18 years or older who sought care for an acute illness for children 8 years old or younger at 2 locations: 1) an inner-city community health clinic, and 2) a demographically similar urban/suburban pediatric ED with >60,000 visits annually. In the clinic, we consecutively invited parents of children evaluated for an acute illness (eg, cough, fever, etc). In the ED, we consecutively sampled parents of nonurgent patients. Parents were recruited during preselected daytime hours for both samples. We recruited parents in 2 care locations to explore the overall care-seeking experience for acute illness rather than focus on only parents who came to the ED or the clinic.

STUDY PROTOCOL

A trained research assistant enrolled parents in the patient room while they waited for treatment or after treatment. Enrollment took place Monday through Friday from 9 AM to 5 PM (to be consistent with office hours) from December 2013 to August 2014 to understand the reasons parents chose the ED or clinic. Eligible participants were legal guardians of children who made a visit to the clinic for an acute illness (excluding revisits for a condition or well-child visits). None of the patients enrolled in the clinic were transferred to an ED, which could indicate an urgent visit. In the ED, parents of nonurgent (defined as a triage level of 5 of 5, the lowest acuity on the Emergency Severity Index) patients were eligible. Triage level remains a robust and efficient method to categorize nonurgent visits at the time of the ED visit.[16] For every patient, the research assistant asked, "Who made the decision to bring the child to the [emergency room] ER/clinic today?" and the person who made the decision was enrolled if they were present. Consent was obtained using a low literacy script after which the research assistant administered: the Newest Vital Sign (NVS) to assess health literacy,[17] the Children with Special Health Care Needs questionnaire to determine chronic illness status,[18] and a survey of sociodemographic information with the option of self-administration or oral administration on the basis of subject preference. The NVS is a standardized measure to screen for health literacy and numeracy.[17] The NVS has differentiated health outcomes, including nonurgent ED use in this population.[19] Per administration protocol, the NVS was scored as low health literacy (0–3 correct of 6) or adequate health literacy (4–6 correct of 6).

Table 1. Brief Interview Guide

Tell me about what brought you to the ER/clinic with your child today.
Tell me about how you took care of your child before you came to the Clinic/Emergency Room.
How did you decide to bring your child to the Clinic/Emergency Room?
What kind of treatment did you think (child's name) needed for his or her sickness or injury?
After you decided (child's name) should see a doctor, how long did you wait to schedule an appointment/come to the ER?
What was the main thing you were hoping for when you decided to come to the clinic/Emergency Room?
Can you tell me in general, what do you do when your children are sick or hurt?
Tell me about what it is like to make decisions about how to care for your child/children when he/she/they is/are sick or hurt.
Tell me about how you decide where to take (child's name) for care when he/she is sick or hurt.
Tell me about how you decide when your child needs to be seen quickly or can wait 24 or 48 hours.
How do you make this decision to take your child to the clinic or ER?

An interviewer (A.K.M. or M.M.), blinded to health literacy status, conducted parent interviews. Interviews were conducted in the examination rooms during available times in the process of care and/or after care in a separate room. Interviews were recorded on an encrypted digital recorder and lasted between 15 and 30 minutes. Interviews followed a semistructured guide (Table 1) to understand: 1) reasons for seeking care for the current illness, 2) reasons for using the clinic, and 3) reasons for using the ED. Questions were developed on the basis of a conceptual framework using the Anderson model of health services utilization[20] and a model of health literacy and health outcomes developed by Paasche-Orlow and Wolf.[21]

Interviews were conducted until thematic saturation was reached when no new themes were revealed for 2 interviews in each location. Interviews were transcribed and coded independently by 2 reviewers (M.M. and A.K.M.). Coding began after the first 10 interviews, and took place in groups of 2 to 5 interviews until thematic saturation was reached. Thematic analysis was performed concurrent with recruitment to allow for influence of future interviews. Disagreements were resolved by consensus agreement. Initial themes were developed through inductive reasoning and new themes were added using a constant comparative method. Definitions were included from the literature if a theme was present to create a shared definition of health literacy skills (eg, health care navigation) to aid coding. Grounded theory was used to create a theory of decision-making regarding the decision to seek care and the location of care-seeking. The theory incorporated themes supported by parents in the ED as well as the clinic regardless of location of care, which allowed for an overall view of health care use for acute illness. Analysis software, NVivo version 10.0 (QSR International, Melbourne, Australia) facilitated the qualitative analysis by integrating the health literacy score, demographic survey results, whether a child had a chronic illness, and interviews with the thematic coding.