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Contributing Factors and Solutions for Inappropriate Use of the Emergency Department

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NORTHERN ILLINOIS UNIVERSITY

Contributing Factors and Solutions for Inappropriate Use of the Emergency Department

A Capstone Submitted to the

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In Partial Fulfillment of the

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By

Lesia Kozych

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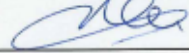
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Contributing Factors and Solutions for Inappropriate
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Abstract

Emergency departments are overwhelmed with the sheer quantity of patients, many of which are there for the non-emergent reasons. The purpose of this project is to identify factors that contribute to emergency department (ED) misuse, initiatives or programs that have been successful in decreasing ED misuse, and ED personnels' opinions on contributing factors and potential solutions. A literature review followed by semi-structured interviews of ED personnel produced the necessary information. Common themes were drawn from participant responses in the interview portion. A major barrier to appropriate use of the emergency department is access to primary care. Others include: lack of education, ease of use, and cost. The major solution addresses increasing access to primary care through expanding clinic hours, use of nurse practitioners or physician assistants, and connecting patients with a provider if they don't have one. Other solutions include: education, fast tracking, and social work.

Contributing Factors and Solutions for Inappropriate Use of the Emergency Department

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NURS 499: Senior Project in Nursing

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Contributing Factors and Solutions for Inappropriate Use of the Emergency Department

Unneeded or inappropriate hospital emergency department (ED) use is a complex and multifactorial problem. It negatively impacts the hospital, staff, and patients themselves. A large proportion of those presenting to the ED are not using it correctly. Usher-Pines et al. (2013) included data to support this claim by stating, “Most studies find that at least 30% of all ED visits in the US are non-urgent...” (paras. 2). When this occurs, precious resources are not used appropriately. The cost of emergency care is one of the largest and most detrimental burdens. In a report published by the UnitedHealth Group in 2019, it was found that “18 million avoidable hospital emergency department visits add \$32 billion in costs to the healthcare system every year” (UnitedHealth Group, 2019, paras. 3). In addition to quantity, the sheer price of services greatly increases cost. Cost of care at a hospital ED is 12 times higher than a physician's office and 10 times higher than an urgent care facility (UnitedHealth Group, 2019). Basic services like lab, pathology, and radiology are about 10 times more costly in the ED than in an outpatient setting (UnitedHealth Group, 2019). Governmental, insurance, or personal resources are squandered on care that can be done at the primary care level more cost effectively. Another problem caused by inappropriate use is ED wait times. As of 2016, 23 million ED visits in the USA had a reported wait time of an hour or more to see a physician, advanced practice registered nurse (APRN), or physician assistant (PA). 10% of which were critically ill (CDC, 2016). Long wait times can prevent semi-urgent or urgent cases from receiving care in a timely manner which can lead to patient complications or death. This is especially true in small hospitals with limited resources and in hospitals located in regions with frequent trauma cases. The final major concern caused by non-urgent use and subsequent overcrowding is staff burn out. Overwhelmed staff can reduce the quality of care and increase rates of medical errors (McKenna et al., 2019). Burn out

can also lead to high turnover rates which negatively impact cost of care and patient satisfaction. Although challenging due to the convoluted nature of the problem, exploring different solutions is imperative to maintain a viable hospital and to alleviate burdens caused by unnecessary care.

Purpose

The purpose of this project is to determine what is causing people to misuse the ED, identify initiatives or programs that have been successful in decreasing ED misuse, and reveal ED employee opinions on contributing factors and potential solutions. These findings can help institutions decrease their rates of ED misuse and ultimately alleviate the economic and emotional burden experienced by the hospital and its staff.

Methods

To gain an understanding of the various factors that contribute to inappropriate use of the emergency department, a deep exploration of current literature will be necessary.

CINAHL, MEDLINE, and EBSCO will be used to answer the following questions:

- What factors lead people to misuse the ED?
- What are some policies, programs, or initiatives that have been successful in reducing the proportion of non-urgent visits in the ED?

To find articles pertaining to these inquiries, search words such as “ER”, “emergency department”, “ED”, “misuse”, “inappropriate use”, and “non-urgent visits” will be used.

To obtain firsthand accounts and opinions regarding this topic, 5 medical personnel from NM Kishwaukee Hospital Emergency Department will be interviewed. This will include: a charge nurse, an outcomes manager, a paramedic, a case manager, and a physician. Only disclosing position and year(s) of experience will ensure participant anonymity. The semi-structured interview will include the following questions:

- From your experience, why do people use the ED inappropriately?
- Why do people use the ED instead of their own physician?
- What is the most common reason for inappropriate use?
- Have you felt any burden from unnecessary visits?
- Has anything been done in this institution to address the problem?
- What do you think can be done to decrease non-urgent visits?

Common themes will be drawn from the participants' responses. Next, qualitative data collected from the interview and information from the literature review will be analyzed and synthesized to draw overarching conclusions about emergency department misuse. The first draft will also include a discussion and conclusion. At this point, the poster will be started.

Consultations with Dr. Sabio and revisions will produce the final drafts of both the paper and poster.

Results

Literature Review

Searching the databases produced about 18 applicable articles. However, after deeper analysis, only 12 were a good fit for this project. They were able to adequately address the two major questions which are what contributes to ED misuse and what can be done to solve this problem.

Contributing Factors

Large quantities of interrelated factors make it difficult to pinpoint the root cause of emergency department misuse. A major contributing factor is insufficient utilization of primary care. In a study compiling survey data from 37 different countries, it was concluded that having access to primary care was correlated with lower rates of ED visits (Ven den Berg et al., 2015).

Access was measured by hours of operation, location, and opportunity for home visits. Many primary care offices operate during work hours making it difficult for people to attend appointments. This barrier was also noted in a US study (O'Mally, 2013).

Another publication focused on the pediatric population and sought to determine which parental factors contributed to low acuity ED visits. Of the 140 caregivers that brought their children (<5 yrs old) to the ED with no-urgent complaints, only 46% reported that they sought care from a PCP prior to ED arrival (Ravi et al., 2021). The 46% that utilized primary care before the ED varied greatly from the group that did not based on race, education, and insurance status. Sixty-two percent of white caregivers sought primary care physician (PCP) guidance first compared to only 24% in the black population. Those with a high school education/GED or less were more likely to not seek primary care. Sixty-four percent of those with Medicaid or CHIP had not sought PCP care compared to 32% of those insured commercially. Results from the socio demographic portion of the survey showed that caregivers with less education, on Medicaid and CHIP, and identifying as Black or African American were more likely to present to the ED with their children for non-urgent reasons without seeking primary care first. Additionally, those that did not seek primary care first believed that ED travel time, wait time, and care was better compared to primary care, further incentivizing ED use (Ravi et al., 2021). Surprisingly, these specific causal factors were actually more accurate in determining PCP use compared to the sociodemographic ones demonstrating that race, insurance, and education are more related to travel time, wait time, and quality of care than they are PCP use (Ravi et al, 2021). This finding shows that there may be deeper explanations for these socio demographic associations like bias and racism.

A retrospective cross sectional analysis supports these conclusions because “Of patients who report having a primary physician, 47% noted the ease of obtaining unscheduled care in the ED as a reason for their choice of site of service” (Honigman, 2013, p. 615). This study also confirmed the demographic patterns noted in the pediatric article claiming that those arriving to the ED for non-urgent care were more likely to have no insurance (self pay) or medicaid, be younger, and non-Hispanic black race (Honigman, 2013).

Interventions

Various interventions have been successful in reducing non-urgent cases presenting to the ED. They include, but are not limited to: education, connecting with a PCP, urgent care centers, and telehealth. New Hanover Regional Medical Center in North Carolina chose to combat high rates of low acuity pediatric patients in their ED by implementing an easily accessible clinic and improving parent education. This was done by creating a clinic that was open Monday through Friday for children aged 0-18 years old with increased numbers of slots for sick child walk-ins. The education portion of the intervention focused on discussing and promoting the clinic. Posters, conversations with providers and office staff, and bookmarks with hours and call line information were used to inform parents about the clinic. Results were notable with a 284 (29.8%) visit decrease in pediatric ED visits after one year of implementing interventions which saved the Medicaid system \$300, 000 (Davis et al., 2018). As they continued to educate parents, they saw increases in pediatric patients visiting the clinic proving that education is a crucial component in decreased pediatric ED use.

Another study reported a 14.5% decrease in non urgent pediatric ED use after a case manager, pediatric nurse, or pediatric social worker discussed the importance of a PCP and helped the parent make an appointment with a provider. Additionally, barriers preventing PCP

use were addressed and worked on for up to three months after the ED visit (Grossman et al., 1998). A systematic review of 38 studies focusing on reducing ED visits found that only 13 ranged from moderate to high effectiveness. Out of those 13 studies, they identified case management to be a consistent indicator for decreased ED visits (Raven et al., 2016). Case managers play a large role in connecting patients to primary care, addressing barriers, educating, and ensuring continuity of care after the patient has discharged.

Telehealth can eliminate barriers regarding location, wait time, and hours of service. Mount Sinai Hospital in New York used a Community Paramedicine tool to connect a team of 3 different providers with a high risk geriatric patient via video call in their home for assessment and triage. 52.8% of all patients evaluated avoided a trip to the ED (Fani et al., 2020).

The use of urgent care as a substitute for the ED can decrease overcrowding, wait times, and cost. Weinick et al., estimates that "...13.7–27.1 percent of all emergency department visits could take place at one of these alternative sites, with a potential cost savings of approximately \$4.4 billion annually" (Weinick et al., 2010, p. 1630). This would create lots of space and time for critical patients that are in dire need of care. Urgent care might also be more accessible than a primary care office because it was estimated that 29% of the US population lives within 10 min drive of a clinic demonstrating accessibility (Weinick et al., 2010).

Some claimed that the implementation of the Affordable Care Act (ACA) would curtail inappropriate use. Non emergent use of the ED actually increased after ACA implementation. A study done in New York analyzing these trends found that increasing insurance coverage would not solve the problem because "social determinants of health, diverse needs of patients, and prevailing patient, provider, and system-related barriers to needed medical care" (Giannouchos, et al., 2021, p. 189) need to be accounted for.

Interview

I had five respondents from the Northwestern Medicine (NM) Kishwaukee Hospital Emergency Department. They were all interviewed individually and privately. My first respondent was the outcomes manager for NM Kishwaukee and NM Valley West hospitals. This participant had 7 years experience in bedside nursing, 4 as a manager, and 5 at the current position. The second participant was a paramedic with 12 years experience in the field and 7 years in the hospital setting at Kishwaukee. The third participant was one of the ED charge nurses with 30 years of nursing experience and 11 years of charge nurse experience in the ED. The fourth participant was a case manager who was a telemetry nurse for 5 years and a case manager for 10. Lastly, the fifth participant was a board certified MD in emergency medicine with 14 years of experience as an attending physician.

Question 1: The first question was an inquiry into why people use the ED inappropriately.

Lack of Education

A majority of the participants mentioned how a lack of education is a major component of inappropriate ED use. The ED should not be used for minor conditions, assessments, or diagnostic tests that can be done in an outpatient setting. Two participants spoke about the lack of education regarding community resources. One even listed examples stating, “The Dekalb Health Department should be used for STD testing, and a convenience clinic can see someone who stubbed their toe.” Not understanding the difference between the roles and services offered at an outpatient and inpatient setting contributes to ED misuse.

Convenience

All except for one participant recognized convenience as one of the biggest incentives for ED misuse. The ED is open 24 hours of the day whereas outpatient settings typically close in the evening or nighttime and sometimes even weekends. People that have full time jobs may find it difficult to make an appointment at a time they are available. Additionally, the ED offers care in a very timely manner. Screenings and diagnostic tests can be done much quicker in the ED compared with the outpatient setting. One participant said, “People are lazy. Why would they wait months for an appointment and test when they can come to the ED and have everything done immediately?” Three others supported the idea that the general public is not willing to wait and be patient. People want answers as quickly as possible, and disregard whether or not this is correct to do. It can also be more convenient to present to the ED because they are required by law to address everyone. This claim was further supported by an explanation from a participant who said, “EMTALA was passed in the United States a long time ago and it legally binds us to provide a medical screening exam to anyone who comes to the ED.” Therefore, it is unlawful to turn patients away, whereas primary care providers are able to do so if they don’t like the insurance one has or if they aren’t taking any new patients.

Cost

All five ED employees claimed that there is a great incentive if the price is small. Depending on which insurance someone has, care in the ED can be very cheap or most likely free. Every participant pointed out that state issued insurance like medicare and medicaid but more specifically medicaid, provides great coverage for ED visits. One participant used himself as an example stating,

I have to pay \$250 out of pocket for ED visits with the insurance that I have. As a result, I think twice before coming to the ED. For minor concerns, I would first consult my physician or urgent care. People who don't have to pay anything for ED services don't have this line of thinking.

When quality service is provided quickly at a lower cost, it's evident why some don't take their concerns to a more appropriate healthcare setting.

Access to Primary Care

Four participants expressed how difficulty reaching a PCP is a large component of preventing ED misuse. Some don't have a primary health care provider, so the ED starts to serve that purpose for them when issues arise. Others do have a PCP but choose to come to the ED because of: clinic hours, long wait time for appointment, and/or cost.

Apathy

Three participants spoke about how the general public just doesn't care. They don't care that valuable time and resources are being used up. This is evident because some clients keep returning to the ED despite being educated on proper use and worked with to address barriers. One of the participants shared an unforgettable story.

I'll never forget this because it appalled me and still does. A father came in early around 8 am with two young boys. The boys had a minor cough and congestion which aligned with typical cold-like symptoms. I go in to see them, and I ask why they didn't visit their PCP. The father replies saying they actually have an appointment on the same day at 11 am, but he didn't want to wait that long. He said they just wanted to get it out of the way early in the morning so they came into the ED. I was in shock because their appointment was just 3 hours away.

Apathy may be linked to a lack of education, however none of the participants spoke in detail about the potential causes of the apathy.

Question 2: The participants were asked to compare the ED with a primary care physician (PCP) in an effort to understand why someone would use one over the other.

Long Wait Time

It is common for available appointments with a PCP may be weeks or even months away. One participant further addressed the issue stating, “COVID really exacerbated this problem. We have had an increasing number of patients struggling to see their PCP in a timely manner.” When patients have a concerning problem that arises, they don’t want to wait months to see a doctor, rationalizing ED use.

Primary Care Provider Shortage

One participant provided a deeper explanation of why patients can’t see their primary care doctor fast enough. There is a decreasing quantity of primary care physicians and an increasing quantity of patients. One of the causative factors for the decline was described by a participant that stated, “Many left primary practice and began to specialize to escape government regulation.” Additionally, there is a very limited number of physicians that would consider taking state issued insurance. This concept was further explained,

Insurance has created a situation where if you’re on a state or Obamacare type program, lots of doctors don’t want to take that insurance because it is very difficult to get reimbursed for services. These regulations make it economically challenging for doctors to accept patients with this insurance. As a result, large groups of people do not have a PCP.

Insurance Coverage

Two participants included that a potential copay may disincentivize those on medicaid from utilizing their PCP or urgent care. For those on private insurance, the ED is more costly than a visit to a PCP or urgent care. All the participants agreed that for those on state issued insurance, it may be more fiscally beneficial to present to the ED instead of PCP or urgent care.

Question 3: The participants were asked about what the most common reasons for coming to the ED are for those who use it inappropriately.

STD Testing

All five participants emphasized how at Kishwaukee Hospital, this is a very common reason for inappropriate ED use. One of the interviewees expressed how shocking this may be, and expressed how frequent it is saying, “STD testing is definitely in the top 3 reasons why people come here when they shouldn’t.”

Common Cold Symptoms

Cold-like symptoms can include congestion, cough, sore throat, fever, and fatigue. Four out of five employees that were interviewed claimed that these are common concerns that patients present with.

Pain

Four participants claimed pain to be one of the top concerns in patients. Oftentimes, this can be abdominal pain.

Miscellaneous

Two participants mentioned medication refills, and a different pair of participants listed alcohol misuse as one of the common reasons for inappropriate ED utilization.

Question 4: This question probed into the personal burdens experienced as a result from unnecessary visits.

Employee Burnout

Large quantities of patients in rooms or waiting for assessment can tire out employees over time especially when the nurse to patient ratio exceeds normal limits. This is true at a lot of hospitals on almost all the floors. Participants offered even more insight on how not critical patients can be emotionally draining. One participant said, “People that don’t need to be here are typically ruder and more demanding.” Another mentioned scenarios describing their behavior,

We serve those with the highest acuity first. Misusers of the ED are typically rated a 4 or 5, and therefore are seen after those that are rated 1 or 2. The long wait times make them very furious, and they can be very mean to staff. These people fail to understand why some patients are seen before them even if they were there first. In other situations, when they finally get a room, they can be very difficult by calling us all the time and requesting things.

Having to be at the receiving end of this behavior can be very difficult and tiring. A few participants commented on how security is called down to the ED on a regular basis to manage some of these types of patients.

Squandering of Resources and Delayed Care for Critical Patients

Resources at the hospital include but are not limited to: diagnostic testing, staff time, and available rooms. Staff at the ED have a limited amount of time to care for all their patients. Their attention may be taken away from a trauma or cardiac arrest because they are dealing with the high demands of the ED misuser. There is also the possibility that a non critical patient may be taking up a room that could be needed for an incoming patient that is in emergent need. Once a

patient gets a room, they are not allowed to remove them from it unless it is for discharge. One participant added that because hospital space and employee time is taken up with non urgent patients, critical patients may experience longer wait times which can have detrimental outcomes.

Question 5: The participants were asked about what NM Kishwaukee Hospital has implemented to address this problem.

MVP Meetings

MVPs or multi-visit patients are discussed in monthly meetings. These meetings consist of a social worker, the outcomes manager, ED manager, and main ED doctor. They discuss what can be done to prevent these same people from coming back to the ED. Oftentimes this includes identifying resources that can help manage chronic diseases in the outpatient setting. All participants mentioned MVP meetings as a helpful tool in attempting to decrease unnecessary ED visits.

Fast Track

Fast track is a workflow that was implemented about four or five years ago at Kishwaukee Hospital. One of the participants explained how it worked and the benefit it served the emergency department. After triage, cases that were categorized as a 4 or 5 are seen by a nurse practitioner. This fast track option is open from 10am to 10pm everyday. This alleviates burden by addressing these patients quickly. ED nurses don't have to balance managing them along with their more critical patients. This hospital has recently hired two physician assistants to help expand their fast track initiative.

Social Worker and Case Manager

A social worker coordinates care and ensures its continuity even after discharge. They can provide resources, educate, and find available primary care providers. One of the participants mentioned that social workers have intentional appointments with clients that come back more than 3 times in a short span of time. They try to investigate why the patient keeps returning and what can be done to address those issues outside of the emergency department. One of the roles of case management is conducting discharge teaching and collaborating with patients and staff to prevent readmission. A participant said that when Northwestern Medicine first took over the hospital, they dissolved the ED case management position believing it to be unnecessary. After many petitions from staff, the position returned. This shows that it is a necessary role in this department.

Outreach Program

This program is specifically designed to keep frequent ED misusers from returning, and was described by only one participant. Hospital staff collaborate with community partners to achieve this goal. Nurses will call patients after discharge to verify that the care plan is being followed through. In addition, they spend extra time trying to understand the root cause of their repeated attendance. For example “If a patient keeps coming from a nursing home, we will call them and probe and try to figure out what is going on at that facility, and why the patient keeps returning.” In the patients that are very likely to return based on their previous history, an employee of Dekalb County elder care services may come to their place of residence to check up on them.

Question 6: The final question investigated the participants' personal ideas on what can be done to decrease non-urgent visits.

Education

Two participants mentioned educating as a potential preventative factor. One participant got creative stating, "There should be a public service announcement that says if you have this go here or you have this go here." People must understand when it is appropriate to take an ambulance or an ED room out of service and when it is not appropriate. The other one claimed that a lack of education regarding available resources also leads people to use the ED. For example, the community may not be aware that the health department in town offers free STD tests. Institutions that offer these types of services need to advertise them, especially to the target audience. Another claimed that education may help with "The general lack of compassion for those in society with legitimate needs."

Increased Quantity of Providers

With long wait times, or doctors not being able to accept new patients, increasing the sheer amount of providers would be incredibly beneficial. One employee mentioned that it would be important not only to increase the number of providers, but to increase the amount of providers that accept state issued insurance. Another cost effective alternative would be hiring nurse practitioners or physician assistants that work with the provider. This can decrease patient load and wait times. One of the participants discussed the importance of collaboration with the PCPs and ensuring that they are on board with any changes that are being discussed in the inpatient setting.

Extended Hours

Two out of the five participants discussed how extending hours in either primary or urgent care can provide more options for clients. For primary care in addition to extending hours, a more specific recommendation was made. “Primary care doctors should have a 1-2 hour window each morning for walk-in sick visits before the scheduled patients are seen.” This can address acute problems that come up and eliminates long wait times that can occur with scheduled appointments.

Discussion

The literature review and interview portions of this project answered the research question in different ways. When discussing contributing factors, the literature review provided a background and introduced trends that are seen with ED misuse. These trends were based on race, age, insurance status, education, and PCP access. Some of these were not discussed with interview participants. The interview was more focused on understanding why this occurs and not necessarily details on who is doing it. Both parts were necessary because the statistics provided an excellent background that was later built upon by the answers from the interviewees. For the intervention section, the content of the literature review and interview portions was more closely aligned because both aimed to describe solutions to the question.

I was surprised to discover that social factors may not be directly related with ED misuse, but instead with the reasons for ED misuse. This means that race, gender, age, and insurance status may add barriers that prevent patients from seeking alternative healthcare instead of the ED. I was also unaware how problematic lack of PCP access is and how great of a role it plays in ED misuse. PCP access was discussed in a majority of articles that focused on this topic and was mentioned by every single participant.

The interview portion of this project contained several limitations. All interview participants had different roles and although this increased variety and provided different perspectives, it also influenced the answers they provided. For example, the physician's scope of practice does not involve insurance. Therefore, when responding to questions, the impact of insurance on ED misuse was not elaborated on. The paramedic is not very involved in programs that prevent readmission. So, although it may exist, because it's not part of his area of expertise, he may not mention it in the interview. When a solution or contributing factor is discussed only once or twice, it may seem unimportant to the reader. As a result, the conclusions drawn by the reader based on collected data may be falsely skewed. Another limitation is that all participants were from the same hospital. This means that some interview responses may only apply to the population that feeds into this hospital. Questions that are most vulnerable would be those discussing common reasons for inappropriate use and interventions that have been implemented to decrease ED misuse. Overall, all data that pertains to contributing factors and interventions may be hospital or region specific and may not apply to every institution. Lastly, the responses from the 5 NM Kishwaukee Hospital employees were sorted into themes. A lot of the responses could have been placed in a few categories. For example, insurance could be discussed under cost in question one, insurance coverage in question two, or increase the quantity of providers in question 6. Because insurance is connected to both cost and PCP use, it was impossible to limit it to one category. Through the literature review and the interviews, it became evident that a lot of the factors are interrelated which makes dividing them into categories too simplistic and overlooks the complexity of this issue.

There is another weakness to this project that specifically relates to the interventions. One of the participants drew my attention to this by saying "There will always be this issue because

emergency is a very subjective term. You can provide all the resources in the world, but at the end of the day no one can be forced to do anything”. Because the ED is open 24/7 and is legally unable to turn patients away, this problem will never be solved completely. Therefore, institutions should strive to decrease rates of ED misuse rather than focusing on complete elimination.

Conclusion

Misuse of the emergency department is very costly for the healthcare system, takes a toll on the providers, and uses resources that are meant for more critical cases. The negative impact is a great incentive for initiating change. This can only occur with a deep understanding of the reasons behind misuse and potential solutions that have been proven effective at other institutions. The five employees at Northwestern Medicine Kishwaukee Hospital provided valuable insight into both of those. The major causative factors that were emphasized repeatedly were lack of access to a PCP and no cost for the services provided. Responses discussing solutions were more widespread among participants, however common themes were still evident. Promoting and improving access to other more appropriate healthcare settings like the PCP, urgent care, or the health department was discussed. Additionally, educating patients on available resources and what appropriate use looks like was thought to be important. Kishwaukee Hospital has taken many steps to decrease misuse of their emergency department, but there is still room for growth. Because decreasing rates of misuse is no small feat, collaboration with community partners may be essential.

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