

5-2012

Chattanooga Community Members Willingness to Use Retail Clinics: A Quantitative Approach

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<http://knowledge.e.southern.edu/gradnursing/27>

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Chattanooga Community Members Willingness to Use Retail Clinics: A Quantitative Approach

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ID #'s 310675 and 421054

May 21, 2012

Thesis

A Paper Presented to Meet Partial Requirements

NRSG 598

Thesis

Southern Adventist University

School of Nursing

Abstract

This study explored the willingness of Chattanooga community members to utilize retail clinics for simple ailments rather than the area EDs. Specifically, community members ages 25-45 were surveyed and asked to rate their willingness to use a retail clinic for their acute healthcare needs rather than the overcrowded local EDs. Additionally, this study explored community members' perceived barriers to use retail clinics. Results were compared between demographic variables such as yearly income, race, gender, and age.

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Chattanooga Community Members Willingness to Use Retail Clinics: A Quantitative Approach

Chapter One

Introduction

Emergency Department (ED) patient overcrowding has been a growing topic for discussion in our health care systems for many years. Greater than 90% of hospitals and EDs were operating at or above capacity in 2002, (Matteson, Weitzen, LaFontaine, & Phipps, 2008). In 2006, there were 119.2 million visits to an Emergency Departments across the nation, an increase of 32% in ten years (Pitts, Niska, Xu, Burt, & Division of Health Care Statistics, 2008). The primary way of accessing health care in the United States (US) is through ambulatory care or on an outpatient status (Pitts et al., 2008). Out of all the ambulatory care received, 11% of that care is obtained in an ED (Pitts et al., 2008). Although the number of people seeking treatment in an ED has increased in the past decade, the number of EDs available to provide that care has decreased, making it difficult to receive timely care in the ED (Pitts et al., 2008). Patients presenting to EDs often see their current condition/s as urgent and when their immediate needs are not met due to long wait times, patients are often unsatisfied with their care (Masson, Bezzina, Siminski, Middleton, & Eagar, 2007).

Background and Significance

The ED is a place to care for and treat emergency medical conditions. Often times due to the current US health system and the lack of primary care providers, patients with non-urgent conditions also present to the ED. Patients are often subjected to long wait times because of real medical emergencies that present to the ED. Non-emergent patients make up the majority of patients that present to the ED (Matteson, Weitzen, Lafontaine, & Phipps, 2008). There are a

number of people who present to any ED with minor illnesses that can be managed at other urgent care or primary care centers. There are a number of reasons that a person might present to an ED. On many occasions, patients view their current health conditions as urgent and are unwilling to wait for treatment elsewhere.

The effects of ED overcrowding are not only frustrating to patients and staff alike, they can also be degrading (Mah, 2009). When a patient is subjected to the wait times involved with ED overcrowding, there is a risk for further injury to that patient because their medical needs are not being met (Mah, 2009). ED overcrowding threatens the dignity of patients who are left without qualified personnel caring for their emergent needs (Mah, 2009). An overcrowded ED also increases the likelihood that medication delays, preventable mortality, and problems that can become a safety hazard may occur and harm the patient (Mah, 2009).

Health care managers are currently seeking ways and opportunities to increase access and control cost for patients without harming the quality of care they receive (Rohrer, Angstman, & Bartel, 2009). With the increasing volume of patients requiring care in the hospital setting, new and creative ways of managing these patients are being established by the health care industry. Memorial Hospital has recently opened a fast track section in their ED in an effort to care for those patients who are less urgent and has reserved their large ED for critically ill patients that present there.

Another barrier that healthcare seekers face is a lack of insurance. There are currently 47 million people in the United States who lack health insurance (Evans, 2010). These uninsured members of society are left with very little options when it comes to accessing health care. As a result, care is increasingly being sought at EDs across the nation.

Many ED patients are aware of the Emergency Medical Treatment & Labor Act (EMTALA) and the fact that they must be seen regardless of their ability to pay. Patients, then, who lack health insurance and/or a primary care provider (PCP), present to the ED with their often non-emergent primary care problems, in hopes that the ED will act as a PCP for them. These patients know that they will be treated and that they will not be turned away. While the EMTALA was created to protect the population from harm, it has also created a sense of entitlement among health consumers (Glass et al., 2004). Consumers now can present to an ED, see a provider, be treated for their current illness, and not be required to pay any monies upfront. Hence, a large number of patients are seen in the ED for non-emergent primary care items on a daily basis.

The fact that EDs are working at or above capacity is a known fact, but what can be done about it? (Matteson et al., 2008). One study found that retail clinics or convenient care clinics (CCCs) are a healthy alternative to ED use for patients' non-emergent cases (Hansen-Turton, Ridgway, Ryan & Nash, 2009). Establishing such clinics is not the only answer. However, by educating patients regarding the clinics' existence and affordability, many of the problems with preventable ED overcrowding may be solved. These retail clinics are currently increasing in numbers across the country but the public has not been informed as to what services they provide and what the benefits are to them. This research study explored the willingness of Chattanooga community members to use a retail clinic instead of area EDs.

Purpose

The purpose of this study was to explore how, and to what extent, the individual differences of the subjects of this study, Chattanooga area adults, are (a) willing to visit CCCs, and (b) what their perceived barriers to use CCCs are. Additionally, this study explored the relationship between the study participant's willingness to visit CCCs and demographics of: income, gender, race, and age.

In 1986, Congress enacted the EMTALA to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to care for a patient within its capabilities, or if the patient requests, an appropriate transfer should be implemented per hospital policy (Glass, Rebstock, & Handberg, 2004). This law mandates that hospitals must treat and see patients regardless of their ability to pay. This also mandates that hospitals provide an appropriate medical screening and examination to every patient that enters the emergency department. The law also requires that unstable patients be stabilized before being transferred to other facilities or discharged (Glass et al., 2004).

Although the EMTALA protects patients from being refused treatment, it does not protect them from the enormous wait times that face each patient entering the emergency department. Currently, the average triage to disposition time for an ED patient is four hours

and 52 minutes (Pitts et al., 2007). Many of these visits are for non-emergent conditions that can be easily treated elsewhere.

While EMATLA protects individuals from being denied care, little research was found on the current problem of ED overcrowding. Without this being dealt with, having legislation such as the ones mentioned only increases patient access and patient volumes to the ED, but does not address how to care for them when they arrive. Patients are now able to receive care when needed but at what cost?

Problem Statement

The problem that guided this research study was that EDs are often overcrowded by individuals who could just as easily find quick and affordable care elsewhere. This study was to explore how, and to what extent, the individual differences of the subjects of this study, Chattanooga area adults, are (a) willing to visit CCCs, and (b) what their perceived barriers to use CCCs are. Additionally, this study will explore the relationship between the study participant's willingness to visit CCCs and demographics of: income, gender, race, and age.

Research Questions

The research questions for this study are as follows:

Research Question 1: How willing are Chattanooga area community members to visit CCCs?

Research Question 2: What are their perceived barriers to visiting CCCs?

Research Question 3: What is the relationship between demographics and their willingness to seek medical treatment in a CCC?

Definition of Terms

For the purpose of clarity throughout the paper, the terms CCC and retail clinic, as defined above, will be used interchangeably. The terms *non-emergent* is used throughout the paper and could be defined differently by many individuals. For purposes of this study, *non-emergent* is used to describe any condition that could easily be treated on an outpatient basis by a PCP or CCC, rather than in an ED.

Theoretical Framework

Imogene King's (1981) Interacting Systems Framework was used for this study. King's (1981) framework involves individuals (personal systems), small groups of people (interpersonal systems), and large societal groups (social systems). King's conceptual framework provides a comprehensive view of three dynamic interacting systems, including: personal system, interpersonal system and social system that is the grand theory. Personal systems involve stress and that stress is a dynamic concept in King's framework, which is especially described as being a part of interpersonal systems (King, 1981). A personal system represents an individual being; their perceptions, self-growth and development time, and their personal space (Killeen, et al., 2007).

Interpersonal systems make up the nurse, patient, and family members and their interactions while an individual is seeking medical treatment in a healthcare facility. These relationships involve communication, interaction, transaction, and stress (Killeen, et al., 2007). In a stressful environment such as an overcrowded ED, these relationships can be tested and strained which could cause further distress to the nurse, the individual and family members who are already stressed by the current medical condition. Interpersonal systems as stated above

were considered to be the specific patients that chose to utilize EDs for their medical rather than that of a CCC.

Social systems are family systems, educational systems, religious systems, and healthcare systems that a person encounters on a daily basis in their life (Killeen, et al., 2007). When an individual and their families present to an overcrowded ED, this system is tested and can result in poor interaction between the nurse and the individual and cause a break in these interconnected links.

Specifically in this study, personal systems were investigated regarding their individual perceptions in choice of health care system and why they chose that particular avenue of care. In application to this study, retail clinics and emergency departments were each separate social systems.

Assumptions

It is the authors' assumption that if convenient care clinics were advertised and made known, the problem of ED overcrowding would be diminished and the ED could be used for true emergent conditions. The authors also assumed that there was not sufficient knowledge by consumers as to the existence of these clinics and the services they provide. Furthermore, the authors believe that if more individuals knew more about CCCs they would be considered as an alternative to healthcare instead of having enormous wait times in a busy ED.

Another assumption that the authors made was that all participants would provide accurate and honest information to the survey. Due to the personal nature of some of the questions asked such as income and age, the authors assume that the participants would answer

those questions honestly knowing that the information they provide will be used strictly for the purpose of the survey and not used for any other purpose.

Limitations

There was one limitation that was addressed. This limitation was that Chattanooga community members were limited to the Samaritan Center, YMCA, Whole Foods, and local area churches. For the Samaritan Center, the authors were only allowed to go on Sunday mornings and the YMCA was limited to Wednesday evenings, and for the local area churches, they only let the authors come conduct the survey on Tuesday nights during their bible study.

There may be many misconceptions from potential participants that may limit the sample size and/or survey responses, which, in turn, limits the data available. The authors took great steps to have the participants recognize that the survey being conducted was strictly for research purposes only.

Chapter Two

Literature Review

A review of literature was performed to access articles that were directly related to this study. Many articles were obtained and only the most relevant were chosen to be reviewed by the authors for this study. A search for literature was conducted using the CINAHL with full text database. Terms searched included “retail clinic,” “convenient care clinic,” and “emergency department overcrowding.” Results included 187 full-text articles matching at least one of the terms above.

Theoretical Literature

Imogene King’s Conceptual System model was used as the theoretical model for this study because the general system framework focuses on nursing care that is geared towards bringing human beings back to optimal health (Killeen, et al., 2007). This system model has explicit goals that are primarily concerned with the health of each individual and focuses on personal systems, interpersonal systems, and social systems coming together to bring a healthy outcome for the individual.

One of the advantages to using this model is it brings to the forefront that interpersonal relations are crucial to the nurse-patient interaction as the integrity of the self was at such risk in any healthcare encounter (Green, 2009). King also emphasized the systematic relations in which people are engaged, personally, interpersonally, and socially (Green, 2009). These relationships are interconnected links for communication in the world of healthcare and nursing.

Research Literature

In October 2006, the Convenient Care Association (CCA) was established to represent the Convenient Care Industry (CCI), which was created to meet the needs of health consumers who desired more accessible and affordable care (Hansen-Turton et al.,2006). There were less than 200 convenient care clinics in operation in 2006. Today, there are now more than 1,000 clinics nationwide seeing patients and more than 3.5 million patient visits being recorded yearly across the country (Hansen-Turton et al.,2006). Most of the CCCs provide not only convenience but quality care at an affordable price. Prices ranges of these visits are between \$59 to \$70 dollars per patient visit (Evans, 2010). Prices are clearly posted in the CCC registration area so the patient knows exactly what they are required to pay prior to receiving treatment.

Patient Satisfaction

In addition to the affordable pricing and convenience of these centers, there is a 98% patient satisfaction rating reported (Evans, 2010). With such a satisfaction rating, it appears the public seems to be embracing the CCC concept.

CCCs are staffed with Nurse Practitioners and Physician Assistants. These clinics not only provide ambulatory care but have become a convenient way for patients to access care without having to go to an ED. Companies such as Target, CVS, Walgreens, Wal-Mart, and some grocery chains are providing such care without an appointment.

Hunter, Weber and Wall (2009), surveyed a retail clinic (specifically MediMin) patients regarding their perceived satisfaction with care received at the clinic. Responses showed that 52% chose MediMin because of the short wait times, 34% because of the low cost, and 61% because of its convenient location. Additionally, patients were asked to delineate where they

would have gone to receive health care that day, if not to MediMin. Of the 456 patients surveyed, 16% stated that they would have gone to an ED. When asked if they would visit MediMin again in the future, 98% of the sample answered “yes.”

ED Overcrowding

Matteson et al. (2008) studied the extent of ED overcrowding and how it is becoming increasingly difficult for patients to access care without lengthy wait times. Their study explored why women were seeking care through an ED for obstetrics or gynecological reasons instead of seeking care through their primary care provider. The predominate reason that was given by these women was that they felt that they had a true emergency at the time and that there weren't many options for after hour access to medical care (Matteson et al., 2008).

There are varied opinions amongst medical personnel as to why a patient would seek treatment by an ED physician as opposed to his or her PCP. In a study conducted in five EDs in New South Wales, Australia, data was collected by physicians, nurses, and patients to identify perceived reasons of each group as to why a patient would go to an ED (Masso, Bezzina, Siminski, Middleton, & Eagar, 2007). The results found that each group had such a different opinion based on their own personal biases (Masso et al., 2007).

The number one reason identified why patients chose to go to an ED was that they felt that their present illness required immediate attention and they could not wait for a PCP to become available, (Masso et al., 2007). ED physicians and nurses believed that patients chose EDs over PCP care because they would be seen regardless of ability to pay and because they would not have to wait for an appointment time with a PCP (Masso et al., 2007).

Reasons for Visiting CCC

Mehrotra, Wang, Lave, Adams, & McGlynn, (2008), found that most visits were related to upper respiratory infections, sinusitis, bronchitis, pharyngitis, immunizations, otitis media, otitis externa, conjunctivitis, urinary tract infections and screening lab test or blood pressure checks. The above listed reasons for visiting a CCC also accounted for 18.1% of PCP visits and 12.0% of ED visits (Mehrotra et al., 2008).

Cost of Care

While retail clinics may be quick and convenient, their potential in reducing ED overcrowding could be annulled if their cost of care is higher than patients with non-emergent symptoms are willing to pay. Thygeson, Van Vorst, Maciosek and Solberg (2008) examined just that, costs of care per visit, at a retail clinic (MinuteClinic, specifically) in Minneapolis, Minnesota, as compared to costs of other conventional sites. They found that total cost per visit was less at the retail clinic studied than at other conventional care sites. However, the researchers are quick to acknowledge that their study did not address care costs overall, considering the possibility that retail clinic staff could miss preventive and/or chronic disease care that a PCP would normally provide, forcing them to spend more money on an additional doctor's visit later. Almost in answer to Thygeson et al., (2008) study, concern regarding overall cost of care, Rohrer et al., (2009) estimated the costs of retail clinic use versus standard medical visits for similar patients over a six month period.

Rohrer et al., (2009) found that medical costs for 260 patients were examined, approximately half of whom were retail clinic patients and half had visited a conventional medical office. Results showed that conventional medical costs ranged from \$22.17 to

\$1,327.65 over the six months following a patient's initial visit. Retail clinic costs for six months after the initial visit ranged from \$43.75 to \$1,050.62. Costs of retail clinics had lower overall costs of care, even over a six month period (Rohrer et al., 2009).

Summary

While each of these studies has greatly contributed to current knowledge of retail clinics and their place in health care today, none of them seem to analyze retail clinics specifically as they relate to decreasing ED overcrowding. Additionally, while a few of these studies have asked retail clinic patients if they would have gone to the emergency department if not to the retail clinic, no such study has determined if Chattanooga community members would be willing to take their concerns to a retail clinic instead.

Given the current problem, changes can and should be made that will not only protect patients from injury due to long ED wait times but also enable the ED medical staff to provide better care to patients who are in critical medical conditions needing faster and more efficient care. One way to accomplish this is to establish convenient care clinics (CCC) near every ED. In establishing such clinics, patients will be given more options when it comes to accessing care.

This strategy is already being used by companies in an attempt to alleviate this health care crisis. CVS Pharmacy has Minute Clinics all around the country to treat non-emergent conditions such as sore throats, upper respiratory infections, rashes, and urinary tract infections that can be easily managed by a PCP (Evans, 2007; Bohmer, 2007).

In these clinics, Advanced Practice Nurses and Physicians Assistants diagnose and treat simple ailments and conditions that would prevent excess use of hospital EDs. Usually these

services are moderately priced with a wait time far less than an ED. The authors' assumption was, if ED patients were made aware of CCCs, knew what services they provided, and at what cost, would community members be willing to present their non-emergent problems to a CCC, rather than an ED?

Chapter Three

Methods and Procedures

Research Design

Quantitative survey research methods were used to document the willingness of Chattanooga community members to utilize CCCs. The authors chose this specific method because it was designed to obtain information about the prevalence, distribution, and interrelations of phenomena within a certain population (Polit & Beck, 2008). This quantitative, exploratory study was designed to augment the existing body of knowledge related to the willingness of community members to visit a CCC. Descriptive statistical analyses were executed. Additionally, inferential statistical analyses including a Pearson correlation was conducted. The level of significance for these inferential analyses was set at the .05 level.

Sample & Setting

Within each selected location, purposive convenience sampling was used. All adult Chattanooga community members present during the selected week's location were invited to participate in the study. The selected locations included several Chattanooga area churches as well as other community establishments, such as, The Samaritan Center, Whole Foods Grocery, and the Chattanooga YMCA. Data collection occurred after arranging specific times with respective church affiliates and community establishments. All data collection from the churches was done on designated Tuesday nights. Conversely community establishments were mainly visited on Sunday afternoons. Each church was visited once with a goal to get an approximately equal number of participants from each Church. However, the Samaritan Center, Whole Foods Grocery, and Chattanooga YMCA were visited twice to obtain a wide variety of

participants. Those who were willing to participate in the study and were 25 years of age to 45 years of age and could read/speak English were included in the study, the resulting sample consisted of $N = 75$.

Ethical Considerations

While the study design was not, by all outward appearances, potentially harmful physically, emotionally or environmentally, the research was conducted in a manner to deliberately protect the rights of all participants. Approval for the study was obtained from the Institutional Review Board of Southern Adventist University. Furthermore, an informed consent (see Appendix A) was obtained from each participant. The informed consent also reminded participants of their right to withdraw from the study at any time without harm or penalty.

Participants were asked to provide personal information on the surveys, but there were no identifying factors on the survey. Each participant was guaranteed utmost confidentiality. Participants were asked to turn in their signed consent forms separately from their surveys. The surveys were then placed in an envelope and sealed by the participant before placing in a covered box with a small slit top; so as to prevent either researcher from consciously or unconsciously keeping track of which survey belonged to any particular participant when data analysis occurred.

Instrumentation

The survey instrument used for this study was created by the authors (see Appendix B) using no other survey tools or analysis to aid in the development. The survey tool consisted of twelve questions regarding general knowledge of and willingness to using a CCC, whether or not the participant would go to a retail clinic rather than to the ED, and general participant

demographics. The survey tool was developed in order to gather data that would provide the answer to the research questions. A 5-point Likert scale was used for a portion of the survey in which the participants were asked to rate their willingness of using a CCC versus the ED if it was easily accessible.

Data Collection

At each of the locations on the specified day, adult participants who voluntarily agreed to participate in this research received an informed consent to read, sign and return to the author, who placed the consent forms in a specified confidential folder. Each consenting participant then received a survey and blank envelope. Participants were asked to fill out the survey alone, without help or suggestions from friends or family. The author was in view of the participant as he/she answered the questions on the survey. However, the author was a sufficient distance away, so as to keep from seeing any of the participant's answers to the survey and prevent the formation of a conscious or subconscious bias or breach of confidentiality. If the participant asked the author for further information regarding the nature of the questions on the survey, the author kindly read the question without giving any further explanation of the questions than what was already on the survey. Participants were then given all the time that they needed to fill out the surveys. At the end of the survey they were asked to place the survey in the envelope provided to them and to place their sealed envelopes in a box with a slit in the top. The information was kept in a safe place at the home of the authors in order to have full and immediate access to the data collected.

Data Analysis

When the completed surveys were compiled, they were processed by the researchers in the Learning Resource Center in Florida Hospital Hall on the campus of Southern Adventist University. The raw data was then entered into the Statistical Package for Social Sciences (SPSS) 20.0 data analysis software where basic descriptive statistics were computed including means, standard deviations, and percentages were computed. Additionally, frequency of occurrence counts and parametric tests, consisting of mean and standard deviation, were conducted, specifically, the Pearson correlation was utilized to examine the relationship between the participants willingness to visit a CCC and their demographics of age groups, races, genders and financial statuses.

Chapter Four

Data Analysis

Introduction

The participants were asked a series of questions about their knowledge level and willingness to visit CCCs for non-emergent conditions. Additionally, they were asked to give demographic information regarding themselves, such as age, race, gender and yearly income level.

Demographics

This study consisted of adults' age 25-45 who could read/speak English. To ensure that only those who reported being age 25–45 and could read and write English all other participant surveys were not included in the study. There were a total of 75 participants in this study.

Gender

Of the study participants, $N = 75$, females made up 63% ($n = 47$). Males made up the remaining 37% ($n = 28$). (See table 1).

Table 1

Response Summary by Gender

Gender	<i>n</i>	Percentage
Female	47	63.0
Male	28	37.0
Total	75	100

Race

Table 2 shows the sample distribution by race. Caucasians were the largest group and represented 64% of the study participants. Next were African Americans at 32%. Asians rounded out the race distribution with 4%.

Table 2

Response Summary by Race

Race	<i>n</i>	Percentage
Caucasian	48	64.0
African American	24	32.0
Asian	3	4.0
Total	75	100

Age

Table 3 represents the age distribution. The age range was from 25-45; the responses were divided into 3 different groupings. Age 25-30 yielded 37%, ages 31-36 were 31% and finally ages 37-45 was 32%.

Table 3

Response Summary by Age

Age	<i>n</i>	Percentage
25-30	28	37.0
37-45	24	32.0
31-36	23	31.0
Total	75	100

Income

Annual income of the participants is described in table 4. The income ranged from \$9,216-\$100,000 annually. The highest income range represented was from \$20,001-\$60,000 per year at 81%.

Table 4

Response Summary by Income Level

Income	<i>n</i>	Percentage
\$20,001-\$60,000	61	81.0
\$60,001-\$100,000+	7	10.0
\$20,000 or less	6	8.0
Missing	1	1.0
Total	75	100

Instrument Reliability

The reliability of a research instrument concerns the extent to which the instrument yields the same results on repeated trials. Although unreliability is always present to a certain extent, there will generally be a good deal of consistency in the results of a quality instrument gathered at different times. The tendency toward consistency found in repeated measurements is referred to as reliability (Carmines & Zeller, 1979). The survey used was designed specifically for this study by the researchers. There were 18 questions compiled for this survey. The survey questions yielded non-interval level data; therefore no Cronbach's Alpha was conducted.

Analysis of Data by Research Question

The findings from each of the three research questions are described below.

Research Question 1

How willing are Chattanooga are community members to visit CCCs?

To better understand the willingness of Chattanooga community members to use a CCC versus an ED the frequencies for the survey item can be seen in Table [5]. The results showed that thirty seven percent of the participants reported that they agree they would use a CCC for simple ailments as opposed to an ED. There were only six participants (8%) who reported that they strongly disagreed to using a CCC. A Pearson correlation technique was used to explore the relationship between the participants and their willingness to use a CCC. No significant difference was found on their willingness to choose a CCC over an ED.

Table 5

Response Summary of Willingness

Willingness	“Yes” (N)	Percentage
Strongly Agree	21	28
Agree	28	37.3
Neither Agree nor Disagree	11	14.7
Disagree	6	8
Strongly Disagree	9	12

Note. N= 75.

Research Question 2

What are their perceived barriers to visiting CCCs?

To better understand what some of the perceived barriers to using a CCC, the authors examined the distribution of frequencies for the survey item (see Table 6). The participants reported that the most frequently perceived barrier was severity of illness at 64%, significantly less was the cost (14.7%). The lack of insurance and transportation were perceived to be the least at 1.3%. Notably the “other” category received 10.7%.

Table 6

Response Summary of Participants Perceived Barriers

Barriers	“Yes” (N)	Percentage
Severity of Illness	48	64.0
Cost	11	14.7
Other	8	10.7
Distrust	6	8.0
Lack of Insurance	1	1.3
Transportation	1	1.3

Note. N= 75.

Research Question 3

What is the relationship between demographics and their willingness to seek medical treatment in a CCC? Statistical analysis was used to further explore the differences between the individual characteristics and the participants' willingness to seek medical treatment in a CCC. A Pearson correlation comparison was utilized to evaluate this information.

Gender

The relationship between participants' gender and their willingness to use a CCC was found to be ($r(73) = .380, p < .001$), indicating a moderately strong, positive relationship between the two variables with a significant p score. Females were more willing to utilize a CCC than were men.

Age

A Pearson correlation coefficient was calculated examining the relationship between participants' age and their willingness to use a CCC. A moderate, positive correlation was found ($r(73) = 0.42, p > .05$). Age is not related to willingness to utilize a CCC.

Race

A Pearson correlation coefficient was calculated examining the relationship between participants' race and their willingness to use a CCC. A weak correlation was found ($r(73) = .078, p > .05$) that was not significant. Race was not found to be related to willingness to utilize a CCC.

Income

A Pearson correlation coefficient was calculated examining the relationship between participants' income and their willingness to use a CCC. A moderately, positive correlation was found ($r(73) = .046, p > .05$). Income is not related to willingness to utilize a CCC.

Summary

In summary, of those who met the criteria for this research study, 63% were female and 37% were male. The ages ranged from 25 to 45 years old of which 37% were in the "25-30" age range, 31% were in the "31-36" age range, and 32% made up the "37-45" age range. The three income level categories were: the "\$20,000 or less" category (8%), the "\$20,001-\$60,000" which contained over half (81%) of the respondents, and the "\$60,001-100,000+" (10%). Since being adult (ages 25-45) and speaking/reading English were inclusion criteria, all 100% of the respondents were included in the study.

Chapter Five

Discussion

Introduction

This study explored the willingness of adults (25-45 year olds) to use CCCs instead of going to an ED. Additionally, this study explored their perceived barriers of using said CCCs such as lack of knowledge of the providers, cost, and lack of transportation, lack of insurance and severity of illness. The participants' age, race, gender and yearly income were compared to their willingness to see if there were any correlations between the factors.

Purpose of the Study

The purpose of this study was to explore how, the individual differences of the subjects of this study, adults ages 25-45 are (a) how willing are Chattanooga area community members to visit CCCs, (b) what are their perceived barriers to visiting CCCs, and (c) what is the relationship between demographics and their willingness to seek medical treatment in a CCC?

Theoretical Framework

This study uses Imogene King's Imogene King's (1981) Interacting Systems Framework as its theoretical basis. King's (1981) framework involves individuals (personal systems), small groups of people (interpersonal systems), and large societal groups (social systems). King's conceptual framework provides a comprehensive view of three dynamic interacting systems, including: personal system, interpersonal system and social system that is the grand theory. Personal systems involve stress and that stress is a dynamic concept in King's framework, which is especially described as being a part of interpersonal systems (King, 1981). A personal system

represents an individual being; their perceptions, self-growth and development time, and their personal space (Killeen, et al., 2007).

Sample

The sample consisted of Chattanooga area community member. A convenience sample was used. Those who reported being 25-45 and read/spoke English were included in the sample (N = 75). Exclusions included those adults under age 25 and over age 45 as well as non-English speaking persons.

Methodology

Quantitative, survey research methods were used to explore the willingness of Chattanooga community members to utilize a CCC versus overcrowding the local EDs. Data analysis performed for this study included computation of descriptive statistics and inferential statistical analyses using Pearson Correlation to compare the relationships between the dependent variable of the willingness to use a CCC and the independent variables related to individual characteristics (gender, race, age, and income level).

Research Question 1

How willing are Chattanooga area community members to visit CCCs? Question eight on the survey found no significant difference for those participants who either strongly agreed or agreed with their willingness to use a CCC for a particular illness. The majority of the participants stated that they would be willing to use a CCC versus an ED.

Hunter, Weber and Wall (2009), surveyed a retail clinic (specifically MediMin) patients regarding their perceived satisfaction with care received at the clinic. Responses showed that

52% chose MediMin because of the short wait times, 34% because of the low cost, and 61% because of its convenient location. Additionally, patients were asked to delineate where they would have gone to receive health care that day, if not to MediMin. Of the 456 patients surveyed, 16% stated that they would have gone to an ED. When asked if they would visit MediMin again in the future, 98% of the sample answered “yes.”

When considering Imogene King’s Interacting Systems Framework, a personal system represents an individual being and their perception of the care that they receive during an encounter with a healthcare entity. Due to the fact that the majority of those who were surveyed found that visiting a CCC were perceived as satisfied with the care they received, Ms. King’s theory is well served here.

The authors can also make the argument that such an encounter would also improve a person’s interpersonal system for if a person is satisfied, then the systems that make up that system, such as the nurse, patient, and family members have all reached a level of satisfaction. Social systems, which are family systems and healthcare systems will also be satisfied. The family members are satisfied because they are confident that their family member received adequate care and the healthcare is satisfied knowing that they provided care that will make the patient want to come back for future visits.

Research Question 2

What are the perceived barriers to visiting CCCs? Question six: What would keep you from using a retail clinic today, answers this research question. When the participant viewed his/her illness as being severe, they believed they would receive better care in an ED versus that of a CCC. This finding is consistent with that of Masson, Bezzinak, Siminski, Middleton & Eagar (2007) who said patients presenting to EDs often see their current condition/s as urgent.

Masso, 2007, states that the number one reason identified why patients chose to go to an ED was that they felt that their present illness required immediate attention and they could not wait for a PCP to become available. In comparison, ED physicians and nurses believed that patients chose EDs over PCP care because they would be seen regardless of ability to pay and because they would not have to wait for an appointment time with a PCP (Masso et al., 2007).

In comparing these results to Ms. King's theory, all three systems, personal, interpersonal, and social systems are greatly affect by the researchers results.

Research Question 3

What is the relationship between demographics and their willingness to seek medical treatment in a CCC? Questions 9-12 on the survey seek to answer research question #2. The authors decided to see if there was a difference in gender, age, race, and income were evaluated for their relationship to their willingness to use a CCC. Females were found to be more likely to utilize a CCC than men were. Age, race, and income were not found to have any significant relationships.

Plan for Dissemination of Findings

A detailed version of the findings will be compiled into a formally written article to be submitted to area ED nurse managers for presentation at their monthly staff meetings. The authors would like to create a poster for presentation at the annual conference for the Emergency Nurses' Association (ENA). This information could potentially provide sufficient data that will aid in ED overcrowding and improve throughput in EDs around the nation.

Recommendations

It is the recommendation of the authors that educational outreach activities need to be done to educate Chattanooga community members on the availability of CCC's. By increasing the age range and expanding the sample setting, the authors believe that this will add to the existing body of knowledge and may help reduce ED overcrowding. From the limited data obtained, it is clear that if community members had that knowledge of the existence of a CCC and knew they type of services that they provided, the use of CCCs would be increased thereby alleviating the burden of overcrowding that EDs across nation face on a daily basis.

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Southern Adventist University

Appendix A

Informed Consent

Title of Research: Willingness of Chattanooga Community Members to Use Retail Clinics

Investigators: Yasmine Swistek, RN, BSN

Casey Waddle, RN, BSN

As you begin to fill out this survey, it is imperative that you read and understand the following study explanation. This statement tells you the purpose, methods, benefits, and risks of this study. Additionally, your rights as participant will be described to you, including your right to, at any moment, withdraw from participation in this study, if you so desire.

Methods

You are being asked to participate in a research study that is seeking to investigate the willingness of Chattanooga Community Members ages 25 to 45 of both sexes to use retail/convenience clinics instead of using the area emergency departments.

This research is being conducted through the use of one questionnaire, containing only four questions regarding the likelihood that you would use a retail clinic instead of the emergency department for your health needs today, your demographics (age and race), and reasons that you would or would not use a retail clinic.

A specific number will be listed on each questionnaire. This number is for data analysis purposes only.

Risks

Answering this questionnaire should not cause any participant any amount of physical or psychological harm.

Benefits

There will be no direct benefits to you, the participant, for answering this questionnaire at this time. However, the information gained will assist in guiding health care facility formation and location in the future, as well as help to target health care education to further prevent emergency department overcrowding.

Confidentiality

All data gathered from these questionnaires will remain absolutely confidential. Your identity as participant will not be disclosed to anyone other than the investigators of this study and Southern Adventist University Institutional Review Board (the committee approving this research project). Informed consents (this form) and any other data containing personal identification will be kept in a locked drawer until completion of data analysis, at which point all data containing personal information will be shredded and destroyed. Furthermore, no information identifying individuals personally will appear on any published articles of this study.

Withdrawal without Prejudice

Your participation in this research study is completely voluntary. Your refusal will not result if punishment or penalty. You are free to withdraw consent of participation at any time, even if you have already signed this consent form.

Costs and/or Payments to Research Participants

There are no costs to you for participating in this research study. Additionally, you will not be paid anything for participating.

Alternative Methods

If you choose not to participate at any time, alternative methods are not necessary, and you will immediately be fully withdrawn from the study.

Questions

Any and all questions regarding this project and its potential and/or actual risks and benefits may be directed to Dr. Ronda Christman (Research Chair) at 423-236-2940 (office number) or Dr. Frances Johnson (Committee Member) at 423-236-2973 (office number).

Agreement

By signing this form, you agree that you have read and understand the above statements and that you are consenting to be a participant in this study.

Signature of Participant

Date

Participant name (printed)

Southern Adventist University

Appendix B

Willingness to Use Retail Clinics Survey

Retail clinics are small walk-in clinics located within many retail stores such as Target, CVS, Walgreens, Wal-Mart, and other chains. They can often provide high quality health care for basic acute needs at little to no cost (depending on whether or not one is insured). The cost per visit at one of these clinics is often less than \$60, when one is paying out of pocket (although various medical insurance plans are also accepted). The wait time is often little to none.

For the following questions, circle the answer best corresponding to your beliefs.

1. Prior to this survey, were you aware that there are retail clinics within your community?
 - a. Yes, I was aware that there are retail clinics within my community
 - b. No, I did not know that these clinics were available

2. If you are aware that retail clinics are in your community, are you aware of the services they provide?
 - a. Yes, I am aware of the services these retail clinics provide
 - b. No, I am not aware

3. Prior to this survey, were you aware that these retail clinics can often offer the same quality care as emergency departments (for specific conditions) but at a lower cost to you?
 - a. Yes, I was aware
 - b. No, I was not aware

4. If you had the knowledge that retail clinics were available to meet your present health concern at a lower cost, would that have made a difference in choosing to utilize their services?
 - a. Yes, it would have affected my decision
 - b. No, I would have come to an emergency department

5. Have you ever used a retail clinic?
 - a. Yes, I have used a retail clinic

b. No, I have not used a retail clinic

6. What would keep you from using a retail clinic today?

- a. Cost
- b. Lack of insurance (ER will see me regardless of insurance)
- c. Transportation
- d. Severity of illness
- e. Distrust of knowledge and/or skill of retail clinic staff
- f. Other: _____

7. Do you have health insurance?

- a. Yes, I have health insurance
- b. No, I do not have health insurance

If you were aware today, of a retail clinic within 5 miles of your area emergency department, rate on the scale below the likelihood that you would go to such a retail clinic with your non-emergent medical conditions, instead of to the emergency department.

8. I would be willing to use a retail clinic, if I knew that one was close and available, instead of to the emergency department.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Circle the option that best describes you, or fill in the blank.

9. My gender is

- a. Male
- b. Female

10. My race is
- a. African American
 - b. Asian
 - c. Caucasian
 - d. Hispanic
 - e. Other: _____

Write your age in the blank.

11. My age is _____ years.

Write your estimated yearly income in the blank.

12. My estimated yearly income is \$_____.

Now, place this survey inside the envelope handed to you at the beginning, seal the envelope, and place it in the specified box. Thank you for your time and cooperation!