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Discharge Alternative Non-Urgent Care Education (D.A.N.C.E.) Protocol: Addressing Emergency Department Misuse

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DISCHARGE ALTERNATIVE NON-URGENT CARE EDUCATION (D.A.N.C.E) PROTOCOL: ADDRESSING EMERGENCY DEPARTMENT MISUSE

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Samantha C. Leon

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DISCHARGE ALTERNATIVE NON-URGENT CARE EDUCATION (D.A.N.C.E)

PROTOCOL: ADDRESSING EMERGENCY DEPARTMENT MISUSE

by

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Abstract

Background: The misuse of the Emergency Department (ED) creates a substantial problem for the health care system, generating gaps in continuity of care, leaving little room for preventative care, and forcing a financial strain on the system. An increasing number of patients are using hospital EDs for non-urgent care despite the availability of alternative care sites such as retail clinics (RCs) and urgent care centers (UCCs).

Purpose: The project's aim was to educate patients who utilize ED services as a source of care for non-urgent complaints with the use of the D.A.N.C.E. protocol. Enhancing the public's knowledge of the ED's purpose and the services available at alternative care sites could provide a potential solution to ED misuse and subsequent overcrowding.

Theoretical Framework: The Andersen Framework of Health Utilization Services was used to guide this project, as it uses a systems perspective to integrate individual, environmental, and provider-related variables associated with decisions to seek care.

Methods: The D.A.N.C.E. protocol was implemented in a pilot project with the use of an educational protocol delineating functions of alternative care sites and EDs. Face validity was established by a staff consensus panel, and the protocol was then distributed to lower acuity patients discharged from the ED. At the completion of the patient's review of the protocol, a survey card was provided evaluating which care site would be selected for the same or similar non-urgent complaint in the future and whether the protocol influenced this decision.

Results: A sample size of 22 completed surveys were returned with 55% (12) selecting the ED, 36% (8) selecting UCC/RC, and 9% (2) selecting their PCP for future care site. The majority of the surveys showed that 91% (20) of the participants found the protocol

influential and 9% (2) selected the protocol had no influence on their future care site decision.

Conclusion: Despite more than half of the patients selecting the ED as their next potential source of non-urgent care, a post discharge intervention did seem to influence care site selection. Several factors presented during this project requiring further examination to better address these patients' health care seeking behaviors.

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I'd like to thank the staff of West Kendall Baptist Hospital Emergency Department for their help and support during the project and throughout the program. It was greatly appreciated. A huge thank you to the Research Department at the hospital as well as to my committee Chair, for their guidance and sound advice on this journey. Finally, I'd like to acknowledge my classmates who are the only small group of people who know firsthand what it was like to complete this DNP program and survive.

DEDICATION

This work is dedicated to the awe inspiring world of nursing that has played such a central role in my life. To all those who have strived to better themselves and refine the art and practice of nursing.

I also would like to dedicate this to my loving family-- the foundation that has kept me standing since day one. For all the family gatherings my laptop attended, for every living room rehearsal of a presentation my sister endured, even to the dogs who were up all night on my lap for every paper and study session; I love you all more than I could ever express.

Finally, I dedicate this work to my mother, Barbara. All that I am I owe to you. I attribute all my success in life to the moral, intellectual and physical education I received from you. Your support, encouragement, and constant love have sustained me throughout my life and always will. I love you.

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INTRODUCTION

The ongoing misuse of the Emergency Department (ED) is creating a substantial problem for the health care system, as it creates gaps in continuity of care. Equally significant, the misappropriation of the ED often leaves little room for preventative care and forces a financial strain on the health care system at both a systems level and an individual level. Enhancing the public's knowledge of the ED's purpose and the services available at alternative care sites, such as retail clinics (RCs) and urgent cares centers (UCCs) can provide a potential solution to ED misuse and help alleviate subsequent overcrowding. By examining the reasons for ED utilization, health care providers can not only understand individual patients' health care needs but also explore and highlight needed changes in the health care system that would more effectively address these needs (Ragin et al., 2005). RCs, UCCs, and EDs share several relevant characteristics and are capable of treating a wide array of patients; however, patients must be made aware of these valuable resources and when to use them in order for a more suitable and safe substitution to take place.

Background

The delivery of modern health services is a complex activity that increasingly relies on multi-professional and multi-service teamwork. An emergency department, also known as an emergency room (ER), is generally part of a hospital or medical center and is required by federal law to provide care to all individuals, regardless of insurance, monetary or legal status. A vital component of the health care system, EDs specialize in

the acute care of patients who arrive without an appointment and are open 24 hours a day, 7 days a week, 365 days a year. Demanding by nature, the ED is often staffed with physicians, nurse practitioners, physician assistants, nurses, and technicians working around the clock to provide care to those in dire need of lifesaving interventions. Yet despite the ED's commitment to acute and emergency treatment, many people utilize the ED erroneously expecting immediate treatment no matter the acuity level of the complaint. Often, many of these patients can be helped at other places so that ED providers can concentrate on those who really need help (McFadden, 2008). It is the one-stop-shop, quick comprehensive work-up notion that is dangerously upsetting the health care delivery system today. Patients can receive care in the ED any time—regardless of the severity of their condition—and in view of the wide array of services available in the ED, patients can receive immediate feedback about their condition. These factors contribute to the fact that all payer groups and age groups contribute to the issue of non-urgent care in the ED (Rosof, 2010).

A common misconception regarding primary responsibility for the misuse, and subsequent overcrowding of EDs, is that uninsured minority populations are most at fault. Anecdotal evidence suggests that this population considers services at a primary care office unavailable to them due to lack of insurance coverage and therefore resort to the ED for care regardless of the acuity of their presenting complaint. According to the Centers for Disease Control and Prevention (CDC), Americans made 136.1 million visits to one of the country's nearly 3,900 emergency rooms in 2012 (Fay, 2014). As of 2010, emergency department overuse costs $38 billion in wasteful health care spending with the average cost of an ED visit being $580 more than the cost of an office health care visit

(National Priorities Partnership [NPP], 2010). It is estimated that more than $18 billion could be saved annually if those patients whose medical problems are considered "avoidable" or "non-urgent" were to take advantage of primary or preventive health care and not rely on ERs for their medical needs (Fay, 2014).

A significant modifier to these statistics is the recent health care reform and enactment of the Patient Protection and Affordable Care Act and its potential impact on ED misuse and overcrowding. The Patient Protection and Affordable Care Act (PPACA) is a federal statute signed into law by President Obama in March 2010. It is designed to take effect in stages over 8 years and includes reforms such as prohibiting insurers from denying coverage for pre-existing conditions, expanding Medicaid eligibility, subsidizing insurance premiums, and providing incentives for businesses to provide health care benefits. The Congressional Budget Office estimates that the number of uninsured persons will drop by 32 million people after all the provisions of the PPACA are in effect in 2019—the Act will still leave 23 million people uncovered, including illegal immigrants and those who choose not to enroll in health insurance policies (American College of Emergency Physicians [ACEP], 2011). With the number of both insured and uninsured patients predicted to fluctuate at a rate unseen in the United States for over a decade, the EDs are undoubtedly at risk for collapse by virtue of their structure unless major health care reform is scrutinized and initiated.

A preexisting form of legal binding within the United States health care system, particularly in EDs, is seen in the Emergency Medical Treatment and Active Labor Act (EMTALA). In 1986, Congress enacted 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 when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay (Centers for Medicare and Medicaid Services [CMS], 2012). Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions, and if the hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented. Essentially, EDs are to provide services and care to all patients in a nondiscriminatory and consistent manner, paralleling the aim of the PPACA. Prior to the PPACA as a national universal health benefits program, hospitals EDs were predominantly the only place in the health care system in which all patients were guaranteed medical care. Incidentally, policy makers in favor of the enactment of the PPACA are also in favor of EMTALA and the notion of universal coverage for individuals.

With EMTALA and PPACA theoretically enhancing access to care, the argument of whether those seeking care are doing so at an appropriate site and utilizing health care resources correctly is still at the forefront of public policy discussion. In the midst of several controversial debates regarding universal health care coverage, however, many policymakers agree with the practice of redirecting non-urgent patients to more appropriate alternative sites in efforts to decrease overcrowding in the ED. Advocates for deferral of care site advantages that include improved ED performance through improved throughput times, decreased wait times, and decreased financial debt with other potential advantages of the deferral of care including the appropriate location for non-urgent care

for non-urgent conditions, shorter wait times, and improved patient satisfaction (ACEP, 2011).

RCs and UCCs are most typically freestanding physicians' offices with extended hours, onsite x-rays and laboratory testing, and an expanded treatment range, including care for fractures and lacerations (Weinick, Burns, & Mehrotra, 2010). RCs, UCCs, and EDs share several relevant characteristics. They provide walk-in care focused on acute conditions and acute exacerbations of chronic conditions. For any given patient, the possibility of safely substituting RC or UCC care for an ED depends on the severity of the condition, the equipment and level of provider training required to care for the patient, and the patient's ability to self-triage to the most appropriate site (Weinick et al., 2010).

Problem Statement

The problem is an increasing number of patients are using hospital EDs for non-urgent care despite the availability of alternative care sites such as RCs and UCCs. The aim of this project is to address the non-urgent use of the ED by increasing awareness of alternative care sites available to these individuals. Addressing these factors can serve as a framework for more effective utilization of health care resources, potentially bridging the gap in continued and appropriate care and improving the health care system overall.

Purpose Statement

The implementation of an educational protocol to address ED misuse was chosen for this project. The purpose of this project was to educate patients who utilize ED

services as a source of care for non-urgent complaints with the use of the Discharge Alternative Non-urgent Care Education (D.A.N.C.E.) protocol. The project also intends to examine the protocol's influence on future care site decisions. Enhancing the public's knowledge of the ED's purpose and the services available at alternative care sites, such as RCs and UCCs, could provide a potential solution to ED misuse and subsequent overcrowding.

Definitions

The following sections defines the terms *emergency departments, urgent care centers, retail clinics, primary care providers* and *Emergency Severity Index (ESI) acuity levels* as they were used throughout this project.

Emergency Departments

The terms emergency department (ED) and emergency room (ER) are used interchangeably throughout this project. With the terms being synonymous, emergency department is defined as a hospital room or area that is used for treating people who need immediate medical care (Merriam-Webster, 2015). This department is open 24 hours a day, 7 days a week, 365 days a year, and is required by federal law to care for anyone who arrives, regardless of insurance or ability to pay. EDs/ERs generally treat people in order of severity and not by time of arrival. At typically higher costs and co-pays independent of severity, this area of the hospital treats medical issues that are life-threatening or limb-threatening or issues that can quickly become so without immediate medical intervention. According to the Centers for Disease Control and Prevention

(CDC), Americans made 136.1 million visits to one of the country's nearly 3,900 emergency rooms in 2012 (CDC, 2012). Because of its convenient hours of operation, comprehensive resources, and inability to decline care, EDs have become the safety net of the health care system and are facing structural and financial strain due to overuse and misuse.

Urgent Care Centers

Urgent care centers are freestanding, walk-in medical facilities that offer extended hours and provide services for less or non-acute illnesses or injuries on a no-appointment basis and are often open for extended hours, including nights and weekends. They are a cost-effective alternative to emergency rooms for the treatment of non-life-threatening medical situations such as cuts, sprains, simple bone fractures, flus and fevers, insect bites, infections, etc. (Fay, 2012). Some centers provide basic laboratory and radiological services, and most can run diagnostic tests and dispense prescriptions. These centers can be owned by doctors, hospitals, or corporations, and many urgent care centers are staffed by nurse practitioners and physician assistants, in addition to at least one board-certified physician (Fay, 2012). They often provide services that are beyond the scope of a retail clinic, when you cannot get an appointment to see your primary-care doctor, but they are not appropriate for emergencies (Consumer Reports, 2009). The Annals of Internal Medicine study found that the average cost of an urgent care visit for three common illnesses—middle ear infection, pharyngitis, and urinary tract infection—was $155, with other estimates that place the average urgent care visit at anywhere from $71 to $125

(Fay, 2012). On average, the costs of services at these centers are considerably lower than an ER visit.

Retail Clinics

Located inside drugstores, supermarkets, and big-box retailers such as Wal-Mart, these clinics treat a limited range of common illnesses and provide some preventive services, such as vaccinations and medication refills (Consumer Reports, 2009). They, like urgent care centers, are open nights and weekends, do not require appointments, and are generally in places where prescriptions can be filled and are usually staffed by nurse practitioners and registered nurses who have advanced training. Unlike urgent care centers, most retail clinics do not have the available resources, such as imaging services, for more urgent conditions. Their accessibility and low cost—$55 to $75 on average if you pay out of pocket or a regular office visit co-pay if your insurance covers it—have made the clinics a popular choice for people who lack health insurance and need basic health maintenance (Consumer Reports, 2009).

Primary Care Providers

A primary care provider (PCP) is a health care practitioner who sees people that have common medical problems (National Institutes of Health [NIH], 2013). This person is usually a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) but may be a physician assistant (PA) or a nurse practitioner (NP). The PCP is often involved in the care of the individual for a long period of time and is responsible for an individual's continued care throughout the lifespan. A PCP is the main health care provider in non-

emergency situations, and his or her role is to provide preventive care and teach healthy lifestyle choices, identify and treat common medical conditions, assess the urgency of medical problems, and direct the patient to the best place for that care, as well as make referrals to medical specialists when necessary (NIH, 2013). These providers often work in an outpatient setting and have varying hours of operation and rates depending on insurance coverage.

Emergency Severity Index (ESI) Acuity Levels

According to Agency for Healthcare Research and Quality (2013), the Emergency Severity Index (ESI) is a five-level ED triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (*most urgent*) to 5 (*least urgent*) on the basis of acuity and resource needs— inclusion of resource needs in the triage rating is a unique feature of the ESI in comparison with other triage systems. This algorithm and rating system is used in the United States to differentiate between emergent, urgent, and non-urgent patient complaints presenting to the ED. The purpose of triage in the ED is to prioritize incoming patients and to identify those who cannot wait to be seen. The ESI is intended for nurses with triage experience or those who have attended a separate, comprehensive triage educational program. The triage nurse performs a brief, focused assessment and assigns the patient a triage acuity level, which is a proxy measure of how long an individual patient can safely wait for a medical screening examination and treatment (Agency for Healthcare Research and Quality [AHRQ], 2011). Acuity is determined by the stability of vital functions and the potential threat to life, limb, or organ. The triage nurse then estimates resource needs based on previous experience with

patients presenting with similar injuries or complaints and national guidelines for emergency care.

The ESI level also assists in determining which patients presenting to the ED can in fact be more safely and effectively treated in a fast-track area, which some EDs have opted for to expedite lower acuity care. The ESI retains the traditional foundation of initially evaluating patient urgency and then seeks to maximize patient streaming: getting the right patient to the right resources at the right place and the right time (AHRQ, 2011). Version 1 of the ESI was originally implemented at two university-based EDs in 1999 and has been revised to its current Version 5 in 2004 (Figure 1).

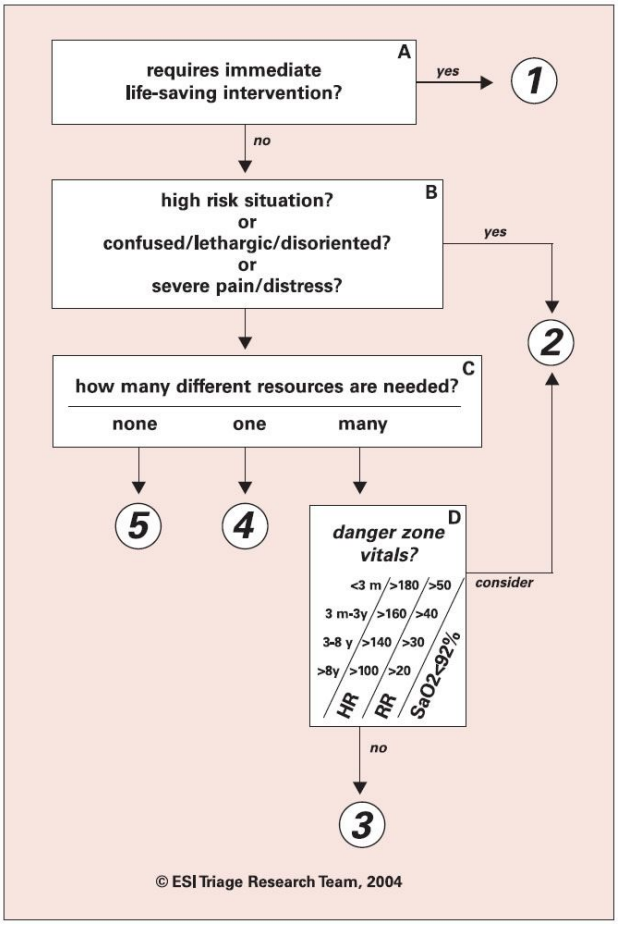

Figure 1. Emergency Severity Index (ESI) algorithm.

Project Objectives

This project sought to achieve the following objectives:

1. To develop an educational protocol entitled D.A.N.C.E protocol to address non-urgent use and overcrowding issues in the ED.
2. To present the protocol, constructed from national evidence-based data on services available at non-urgent care sites and the ED to a staff consensus panel for review and face validity.
3. To initiate a pilot test of the D.A.N.C.E. protocol over a 1-day period at a local hospital to evaluate the effectiveness of the protocol.
4. To analyze the D.A.N.C.E. protocol's influence on the patient's future care site decision for the same or similar non-urgent complaint by evaluating a post intervention survey card completed by the patient after complete discharge from the ED.

Project Questions

The project's questions included the following:

1. Will the D.A.N.C.E. protocol affect patients' health-seeking behavior when determining appropriate care sites for non-urgent, lower acuity health complains?
2. What is the likelihood the D.A.N.C.E. protocol can be an effective educational protocol on a system wide level to reduce the misuse and overcrowding of the ED by non-urgent patients?

Theoretical Framework

The Andersen Framework of Health Utilization Services was utilized to guide this project as it uses a systems perspective to integrate individual, environmental, and provider-related variables associated with decisions to seek care. The Health Services Utilization Framework can be used for the purpose of discovering conditions that either facilitate or impede utilization of health care (Andersen, 1995). Developed as a sociology model, the most current version of the Andersen model describes four components that interact and assist in understanding utilization of care: Environment, Population Characteristics, Health Behavior, and Outcomes (Figure 2).

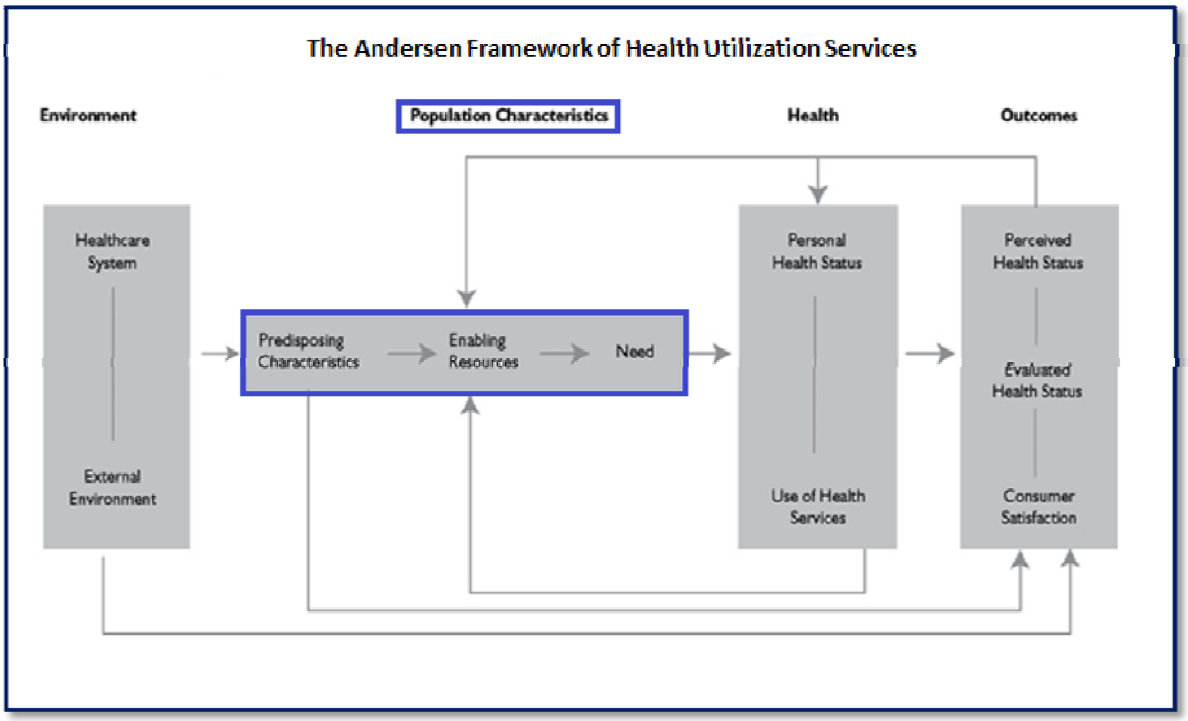

Figure 2. The Andersen Framework of Health Utilization Services (Andersen, 1995).

The model proposes that the combination of these characteristics enables or impedes the use of health care services with this decision being highly individualized and interactive with and/or dependent on certain components. While all four components are

important to the framework, for the purpose of this project, the Population Characteristics segment was the area of concentration, as it is unique to the individual. The focus was on the three main characteristics of the component Population Characteristics: *predisposing characteristics*, *enabling resources*, and *need* (Figure 3).

Predisposing characteristics are the socio-cultural characteristics of individuals that exist prior to their illness and encompass social structure, health beliefs, and demographics (Andersen, 1995). These factors are facets such as race and age, with social structure including education, occupation, ethnicity, social networks, interactions, and culture. Health beliefs are further defined to include attitudes, values, and knowledge individuals have regarding disease processes and the health care system in general. Demographics include age and gender.

Enabling factors incorporate family and community resources and accessibility of those resources. Financing and organizational factors are considered to serve as conditions enabling services utilization (Andersen, 1995). These factors include income, transportation, health insurance, and a primary source for health care. They also include means of transportation, travel time to the health care facility, and waiting time for health care. Social relationships are also potentially an enabling resource, overlapping slightly with predisposing characteristics. The community is a reflection of available health resources, such as facility space, wait times, and adequate staffing levels (Andersen, 1995).

Finally, perhaps the most individualized aspect of the model is need. Essentially, this factor includes functional and health problems that generate the need for health care services. Needs are divided into two aspects: perceived need and evaluated need.

Perceived need in this framework is defined as how people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether they judge their problems to be of sufficient importance and magnitude to seek professional help (Andersen, 1995). Evaluated need falls on the decision and expertise of the health care professional acting as the source of care and ultimately fulfilling an individual's health care need. Evaluated need represents professional judgment about people's health status and their need for medical care (Andersen, 1995).

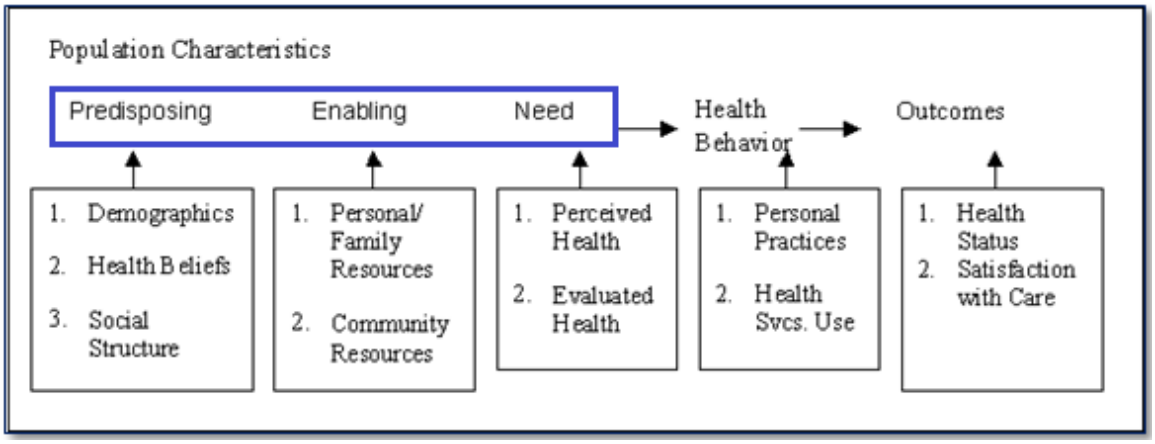

Figure 3. The Andersen Framework of Health Utilization Services expanded population characteristics behavioral model of health services (Andersen, 1995).

Significance to Nursing

Historically, nursing's underpinnings have been rooted in increasing the individual's awareness of health in order to foster independence and empowerment through enhanced knowledge. As a result, efficient utilization of health care provisions takes place and ultimately allows for a more feasible and fluid health care system. In 2006, the Institute of Medicine (IOM) called for improved operations management to

support ED efficiencies and mitigate the effects of overcrowding (IOM, 2006). Recently, the IOM consensus report called for changes across the nursing profession that will benefit patients, families, and the global community. According to this report, nurses should practice to the full extent of their education and training; nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; and nurses should be full partners with physicians and other health care professionals in redesigning health care systems in the United States (IOM, 2010).

A major advantage of nurse practitioners (NPs) is that they possess an advanced breadth of knowledge and expertise in health care *and* nursing which renders them capable of managing a broad spectrum of clinical issues, despite their specialty or setting. Two hallmarks of the NP profession are proficiency in cross-cultural competencies and proficiency in caring for patients with non-emergent problems of an acute or chronic nature (Abbot, 2012). Furthermore the NPs' emphasis on health promotion and disease prevention is integral in today's evolving health care climate. NPs are expanding on their education to the doctoral level as they are expected to be involved in system-wide and nationwide improvements in health care policy. This education also incorporates the appropriate use of important health care resources including EDs, UCCs, and RCs. Commonly employed at RCs and UCCs, nurse practitioners continue to be a great resource for these alternative care sites as they are highly skilled, highly trained, well accepted by the general public, and cost effective professional providers (American Academy of Nurse Practitioners [AANP], 2006). With the expansion of advance nursing education to a doctoral level, NPs, or Doctorate of Nursing Practice (DNP), continue to

demonstrate a progressive and profound knowledge in practice that will undoubtedly serve as a impressive asset in our shifting health care system.

DNP Essentials

The American Association of Colleges of Nursing outlines expectations for advanced nursing practice in *The Essentials of Doctoral Education for Advanced Nursing Practice*, henceforth referred to as *DNP Essentials* (American Association of Colleges of Nursing [AACN], 2006). The significance of this project can be directly identified and justified by the eight DNP Essentials. These essentials are: *Essential I: Scientific Underpinnings for Practice; Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking; Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice; Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care; Essential V: Health Care Policy for Advocacy in Health Care; Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes; Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health* and *Essential VIII Advanced Nursing Practice.*

Under Essential I, the DNP is expected to use scientific-based theories and concepts to evaluate outcomes as well as develop and evaluate new practice approaches based on nursing and theories from other disciplines (AACN, 2006). The project itself is the essence of this Essential—not just in the approach to scientific inquiry itself but in the topic being examined as well. By use of scientific theories and procedures, the project

examines a population's health-seeking behaviors and knowledge deficits in awareness of the role of alternative care sites.

Essential II expects the DNP to be able to develop and evaluate care delivery approaches that meet current and future needs of populations based on scientific findings in nursing and other clinical sciences, as well as organizational, political, and economical science (AACN, 2006). This Essential also expects the DNP to develop, evaluate, design, and direct quality improvement methods that include addressing ethical, financial, and patient-centered care. All of these expectations are met through the aim, which is implementing an educational protocol that enhances public's knowledge of available alternative sites more appropriate for care.

With scholarship and research being the hallmarks of doctoral education, Essential III focuses on the translation of new science, its application, and evaluation (AACN, 2006). It is expected of the DNP to generate evidence through practice to guide improvements in practice and outcomes of care. The entire process of this project, from beginning to end, allows the DNP to use analytical methods that critically appraise existing literature in a scholarly attempt to determine and implement the best evidence-based practice for a set population. In doing so, it simultaneously showcases a fundamental understanding of the relationship between research and practice. In conducting this study, the DNP is applying relevant findings to develop practice guidelines and ultimately improve practice. Under this essential, it is also expected of the DNP to design evidence-based interventions, predict and analyze outcomes, examine patterns of behavior and outcomes, and identify gaps in evidence for practice (AACN, 2006). This essential certainly stands at the core of this project.

Under Essential IV, the project allows for the DNP to design, select, use, and evaluate programs that evaluate and monitor outcomes of care, care systems, and quality improvement including consumer use of health care information systems (AACN, 2006). Through this project, analysis and identification of significant elements involved in patient's health-seeking behaviors can be examined and the use of patient care technology can potentially be further explored. Findings could present an opportunity to explore the use and evaluation of health care information systems dependent on further study on related variables associated with decisions to seek care.

Essential V exemplifies that the DNP's engagement in the process of policy development is central to creating a health care system that meets the needs of its constituents (AACN, 2006). This project could serve as a platform from which the DNP can educate others, including policy makers at all levels, regarding nursing, health policy, patient care outcomes, and related issues from the perspective of consumers in health care behaviors and needed reform. The project serves as the groundwork that can facilitate the delivery of health care services and address health care needs in this particular population.

Essential VI stresses the importance of effective communication and collaborative skills in the development and implementation of practice models, peer review, practice guidelines, health policy, standards of care, and/or other scholarly products (AACN, 2006). The project exemplifies a collegiality among a community of highly skilled and knowledgeable individuals from multiple professions of the health care system in attempts to better serve this population and utilize health care resources as effectively as possible.

Under Essential VII, the DNP is expected to evaluate care delivery models and/or strategies using concepts related to community, environment and occupational health, and cultural and socioeconomic dimensions of health (AACN, 2006). The project itself embraces the community at large as it adds to the current body of knowledge supporting strategies aimed at improving all dimensions of health. Further supporting this is the theoretical framework to be used to guide the project on the community as a whole.

Finally, under Essential VIII, the DNP is expected to design, implement, and evaluate therapeutic interventions based on nursing science and other sciences (AACN, 2006). The project focused on the already established strengths of the NP and applies them to the investigator's ability to effectively assess and educate individuals on the proper alternative provision of health care. This Essential showcases the ability of the DNP to demonstrate advanced levels of clinical judgment, systems thinking, and accountability in designing, delivering, and evaluating evidence-based care to improve patient outcomes. The DNP's conceptual and analytical skills in evaluating the links between practice, organizational, population, fiscal, and policy issues are showcased in the implementation of the project.

Significance of the Project

It was anticipated that this study will be significant in the areas of not only nursing but in health care practice, health care delivery, health care outcomes, and health care policy as well.

Health Care Practice

Studies have shown that the utilization of NPs in the ED is a practice that has evolved to address the non-urgent needs of patients at a lower cost. According to Abbot (2012), a comparative study showed that utilizing NPs in the ED for non-emergent cases reduced wait times, lengths of stay, and the number of patients who leave without being seen compared to ED without NPs. While there is a need for further studies to confirm and extend these findings, there is compelling evidence to suggest that increasing the use of NPs in other realms of the health care system may be as advantageous especially in areas of non-urgent care. As our health care system shifts to accommodate the needs of a rapidly growing nation and different areas of health care accept NPs as key stakeholders in the provision of quality care, alternative care sites present a promising opportunity for advanced nursing practice as NPs are well suited to care for the majority of patients with non-urgent problems.

Health Care Delivery

ED overcrowding is recognized as a national problem that hinders the delivery of emergency medical services. Overcrowding in the ED has been linked to decreased quality of care, increased costs, and patient dissatisfaction (Abbot, 2012). Delivery of acceptable patient care under such circumstances requires a fundamental reordering of ED priorities, policy, and procedures. Yet in the face of a much-needed redesign in the delivery of care, few interventions that are in place target the education of patients responsible for ED misuse and subsequently overcrowding. Solutions to the complex problem of inappropriate ED use will require payers and hospital systems to work

together to design and invest in novel, targeted interventions (McWilliams, Tapp, Barker, & Dulin, 2011). By enhancing an individual's knowledge of available alternative care sites, which are generally less time consuming and less costly, the delivery of health care can focus on more tactful utilization of resources.

Health Care Outcomes

By educating these individuals on alternative care sites, the patient's ability to self-triage to the most appropriate site fundamentally impacts health care outcomes by seeking suitable and equivalent care. Expanding on this concept and tailoring interventions to the individual, which in turn affect the overall health care system, the implementation of a discharge educational protocol showcases the NP's astute clinical judgment and evaluation of evidence-based care to improve health care outcomes. Most importantly, once individuals have been educated on the appropriate site of care for their non-urgent complaints, it can be assumed that they will continue to seek care accordingly and eventually the dynamics of the proper application of provision will positively affect health care at multiple levels.

Health Care Policy

Nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act, legislation that represents the broadest health care overhaul since the 1965 creation of the Medicare and Medicaid programs (IOM, 2010). Although NPs as a group have been employed in emergency care for more than 35 years, few studies have been conducted to ascertain how they—and their skills and experience—can best be

utilized; the multifaceted problems that emergency medical service is facing deserve further investigation into the utilization of NPs and demand urgent attention from researchers and policymakers (Abbot, 2012). With the advent of NPs at the forefront of educating individuals on appropriate health-seeking behaviors, a consistent and effective health care system can be reconstructed. If health plans, policy makers, and providers want to reduce use of the ED for non-urgent problems, they must ensure that their interventions are tailored to address the needs of the populations they are designed to serve (Uscher-Pines, Pines, Kellermann, Gillen, & Mehrotra, 2013). Emerging into health care as a key element to reform, NPs are rapidly being placed at the political forefront to policy changes that embrace better care of these patients.

Summary

An increasing number of patients are using hospital EDs for non-urgent care despite the availability of alternative care sites such as RCs and UCCs. Enhancing the individual's knowledge of available alternative care sites for non-urgent complaints was fundamental to this project. Having significant impacts on health care practice, outcomes, delivery, and policy, the project served to explore an intervention tailored to a specific group with dynamic characteristics. With the expansion of advance nursing education and practice, NPs are proving to be an even larger asset to our shifting health care system as they enter greater roles as DNPs. Increasing patients' awareness of available alternative care sites, such as UCC and RC, over the use of the ED for a non-urgent complaint can help identify needed changes in our health care system in order to better serve the community.

SECTION TWO:

REVIEW OF THE LITERATURE

Introduction

An increasing number of patients are using hospital EDs for care of non-urgent conditions that can be treated in alternative care settings. The individual's understanding of appropriate alternative care sites for care of non-urgent complaints should be addressed in order to streamline a more efficient treatment of these patients and reduce the misuse of the ED. Non-urgent ED use is at the forefront of medico-political agendas, and diversion of these patients has been entertained as a management strategy (Afilalo et al., 2004). Because non-urgent ED users are likely a diverse group, the better approach might be to try to break up non-urgent ED users into different strata with the precise issues or challenges identified so that the correct intervention(s) can be applied (Uscher-Pines et al., 2013). Identifying these factors can also serve as a framework for the implementation of a discharge alternative non-urgent care education protocol for these patients and potentially bridge the gap in the misappropriation of health care resources.

A review of the literature reveals that the use of EDs for non-urgent care has been examined for the past three decades. Yet, despite the growing and consistent evidence of its detrimental effects, little use has been made of this information regarding implementing strategies that encourage or enable patient's health-seeking behaviors appropriately. A search of relevant literature across disciplines was conducted to explore the phenomenon of overcrowding and non-urgent care in the ED. Using First Search, Lilinet Online, and ProQuest Direct search engines, the following computerized

databases were used for this search: the Cumulative Index to Nursing and Allied Health Literature (CINAHL); Dissertation Abstracts; Educational Resource Information Center (ERIC); Health Reference Center – Academic; Medicine, Modern Language Association (MLA); and Periodical Abstracts (PerAbs: Covering business, economics, literature, religion, psychology, and women studies). The key words used in the search were emergency department overcrowding, ED overcrowding, ED overuse, ER abuse, motivating factors, alternative non-urgent care, perceptions of care, barriers to ED care, Nurse Practitioners in ED, and retail clinics versus emergency rooms cost. Citations were limited by language to English and by subject to exploration of the concepts. A limitation was imposed to find literature published since 2009 with classics sought by reviewing citations in the published works. A random selection process delimited the profusion of theoretical references that were found. Additionally, over 10 research studies were reviewed in which the occurrences of ED overcrowding and non-urgent use of the ED were explored. Synthesis of the literature reveals what is known and not known about ED overcrowding and patients' understanding of alternative care sites.

Emergency Department Overutilization

An international phenomenon, overcrowding in EDs is described in emergency medicine literature as a major public health problem because of its consequences: degradation of the quality of care (e.g., prolonged waiting times, delays to diagnosis and treatment, and delays in treating seriously ill patients); increased costs (e.g., insurance coverage and unnecessary diagnostic investigations); and patients' dissatisfaction (Gentile et al., 2010). The number of these non-urgent visits continues to rise, and their

reduction requires a system wide reform. ED overcrowding is a serious and well-documented problem—of an estimated 14 million visits to hospital emergency departments, only 12.9% are considered emergent cases; with 62% of all emergency departments described themselves as over capacity (Twanmoh & Cunningham, 2006) in the United States.

An extensive, international literature review reported that 4.8% to 90% of ED patients were potentially non-urgent cases, with a median of 32.1% (Gentile et al., 2010). Despite exceptionally long wait times documented, much of the literature has found that patients are willing to wait extended periods of time for care, regardless of acuity. In their French study, Gentile et al. (2010) found that when given the option of being treated in the ED or a nearby facility for their non-urgent complaints, nearly one-third of patients refusing reorientation would be willing to pay an extra fee to be treated in the ED (Gentile et al., 2010). This finding is significant in that it points to motivations behind seeking care despite lower acuity complaints. The aim of this study was to assess the willingness of non-urgent patients to be reoriented to primary care units (PCUs)—alternative structures located near hospitals—and to collect the reasons that prompted them to accept or refuse. In this cross-sectional study, patients were interviewed at a single French hospital where 85 patients considered non-urgent by a triage nurse were asked to respond to a questionnaire. The results showed that most patients went to the ED autonomously (76%) with the main reasons for using the ED were difficulty to get an appointment with a general practitioner (22.3%), feelings of pain (68.5%), and the availability of medical services in the ED, such as imaging, laboratory tests, and drug prescriptions (37.6%). Traumatisms and wounds were the main medical reasons for

going to the ED (43.5%). More than two-thirds of responders (68%) were willing to be reoriented towards PCUs (Gentile et al., 2010). Despite a small sample size, the study provides significant data regarding patients' willingness to be reoriented to a more appropriate care site based on urgency and actualizes the possibility of policy change involving these sites.

Non-Urgent

Interestingly, a common limitation seen in the majority of the literature is the lack of an official definition to the term "non-urgent." While all the studies reviewed explicitly explain the acuity designation of their patients, that is a level 4 or 5 based on a five-level triage algorithm, and no two studies used the same definition of the term non-urgent. According to Agency for Healthcare Research and Quality (2013), the Emergency Severity Index (ESI) is a five-level emergency department triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. Inclusion of resource needs in the triage rating is a unique feature of the ESI in comparison with other triage systems. Yet, the literature incongruently describes the same system. Other severity indexes exist and are used at the discretion of the hospital system as well as the country or region the emergency department is located. A well-recognized and validated triage system is the Canadian Emergency Department Triage and Acuity Scale (CTAS) which has five acuity levels consisting of - Resuscitation, Emergent, Urgent, Less Urgent and Non Urgent (Elkum, Barrett, & Al-Omran, 2011). While all systems are quite

similar and facilities generally responded with a comparable level of care and use of resources, there is still no evidence of a universal designation of levels of acuity.

With no uniformity in a definition of the term, greater confusion was found in categorizing the motivating factors for seeking care in the ED. Thus, non-urgent became the standard term while the care of these patients continues to be a major point of controversy. Further studies revealed that the patients' perception of appropriateness in seeking care had less to do with the level of medical urgency and more with the convenience of the ED services. In a secondary analysis from a cross-sectional study with sequential sampling in the EDs of five Quebec tertiary care hospitals. Afialo et al. (2004) found that the reasons given by non-urgent patients for not seeking primary care provider care were accessibility (32%), perception of need (22%), referral/follow-up to the ED (20%), familiarity with the ED (11%), trust of the ED (7%), and no reason (7%). Similar studies have acknowledged that the term non-urgent is poorly defined, and its clarification is essential in determining a solution to their unfitting use of the ED. They often defined a non-urgent visit according to medical criteria such as calling it a "minor medical problem that is non-acute, non-life-threatening" (Durand et al., 2012). Identifying these factors potentially plays a pivotal role in the designing of diversion interventions that incorporate the multifaceted dynamics of the populations seen in the ED and their equally multidimensional reasons for utilizing it.

Fueling a portion of this controversy is the cost of treating these non-urgent patients in the ED. In the United States, 56%, or roughly 7 million visits, are potentially avoidable; reducing this trend represents a significant opportunity to improve quality and lower costs in health care (NPP, 2010). In an effort to reduce these costs and

overcrowding, numerous alternative sites, such as Urgent Care Centers (UCCs) and Retail Clinics (RCs) have been created to provide non-urgent care. One study found that between 13.7% and 27.1% of all emergency department visits could be treated at one of these alternative sites with a potential cost savings of approximately $4.4 billion annually (Weinick et al., 2010). With roughly 2% of national health care spending potential saved with the use of these alternative sites there is stirring initiative to determine responsible parties for the improper use of the ED. In their study, Weinick et al. (2010) compared care at the three sites (RCs, UCCs, and EDs) in attempts to examine the extent of which a safe substitution could be made and found that overall, a total of 27.1% of all ED visits could be managed at a RC or UCC. This study reinforces the capacity of these alternative sites to care for these non-urgent patients and help reduce ED misuse and overcrowding.

Who's Responsible?

Public perception often point to the uninsured individual as the responsible party for ED misuse. Yet, despite the compelling statistical evidence found in multiple studies over the past decades stating differently, the blame for misuse of the ED is still being placed on the uninsured populations. In tracking this trend over the years, there now is evidence to support that it is not only the uninsured but the insured and newly termed underinsured, who are at fault for the misuse of the ED. While the uninsured still partake in the misuse, a study shows that the increased use of the ED over a decade (119 million U.S. visits in 2006, compared with 67 million in 1996) is actually driven by more visits from insured, middle-class patients who usually get their care from a doctor's office

(Meisel & Pines, 2008). It appears the uninsured misuse the ED comparatively proportionately to those with insurance according to the studies reviewed. While uninsured adults were more likely than those with private health insurance or a public health plan to visit the emergency room due to having no other place to go, adults with public health plan coverage were twice as likely as those with no health insurance to visit the emergency room because their doctor's office was not open (CDC, 2012). It is clear that interventions should be aimed at not just the uninsured population but the insured as well.

Interestingly, another study found that the communities with high ED usage do not necessarily have the highest number of uninsured, low income, racial/ethnic minorities, or immigrants (Cunningham, 2006). Moreover, the most recent evidence suggests that younger age, convenience of the ED compared with alternatives, referral to the ED by a physician, and negative perceptions about alternatives, such as primary care providers, all play a role in driving non-urgent ED use (Uscher-Pines et al., 2013). Sufficient evidence suggests that a reform in the health care system should be aimed specifically to the population responsible for the overall misuse of the ED and not toward an anecdotal offender. In short, attributing the increase in visits to the uninsured oversimplifies a complex problem and thereby subverts meaningful debate on how best to develop innovative and appropriate solutions to the problem of ED crowding (Weber et al., 2008).

Access

The increase in ED use may be attributable to lack of ready access to primary care and other structural problems in the health care system (Weber et al., 2008). The

numerous studies reviewed highlighted other factors that affect patient's decisions when seeking care. The New England Healthcare Institute notes that lack of timely appointments and after-hours care also drive patients to the ED (Rosof, 2010). Multiple studies noted that patients often reported anticipating that their primary care providers would refer them to the ED, and so they preemptively make the choice to go to the ED. With the prioritization of cost containment, many offices rely on staff with less training to answer phone calls, and studies have shown that office staffs often refer patients with non-urgent conditions to the ED (Adesara, Spencer, & Bost, 2011). There is noted liability in allowing office staff members who are often inexperienced in medical care or nursing to perform their own version of phone triaging, specifically in combination with observable conflicts of interest of scheduling an unexpected patient to the office. Seeing additional patients may result in additional work or hours for the staff (Adesara et al., 2011). A main theme noted throughout many of the studies was the perceived convenience of the ED by otherwise unknowing office staff as well.

Acknowledged in virtually all of the reviewed literature is the ED's role as a safety net in the current health care system. Required by law to care for all patients regardless of ability to pay, EDs have fallen into the "safety net for safety nets" role, and overcrowding threatens public health by compromising patient safety and jeopardizes the reliability of the entire health care system (Rivers, 2003). Insurance status had a particularly solid presence throughout the research of the ED, being often the only access to health care for some individuals. As mentioned in an earlier section, visits to the ED are due to having no other place to go. These binding legal obligations coupled with patient's misuse unconsciously subject the ED to an exploitation that will not be able to

sustain itself unless significant reform occurs. However, studies have shown that patients are acting as rational consumers when choosing the ED for care. One study points out that even after being interviewed and made fully aware of all alternative health structures available, patients continued to choose treatments and services provided in the ED. A common limitation in several studies was the patient's reluctance to utilize a more appropriate alternative site despite education for unjustifiable reasons. Interviews showed that patients are able to use this information to make their own choice when selecting care providers and yet continued to choose the ED. For them, among all health care resources available, the ED is the most suitable place and the most efficient provider that can fulfill their medical needs immediately (Durand et al., 2012). Therefore, although their acuity and self-triage is not appropriate for the ED setting, the patient's progression of thoughts can be seen as a rational decision when seeking fulfillment of their needs.

Clinician vs. Patient

A growing trend noted in the literature is the interest in the opinions of the health care professionals in the ED and why they feel patients are using the ED for non-urgent care. A result of interviews with physicians and nurses working in the ED revealed that the "rational consumer" notion was not shared by these health care professionals. These health care professionals stigmatized patients as "abusive and irresponsible consumers" of health care resources and felt patients use EDs to be seen earlier and faster than their medical condition warrants (Durand et al., 2012). They also felt their training on handling life-threatening emergencies was being wasted on these patients. Interestingly,

studies found reverse ranking on level of importance between patients and health care staff. There will always be a certain disconnect between what patients perceive as appropriate use and what clinicians see as appropriate, but the reasons given by patients make such good sense that they call in to question the whole issue of using the term inappropriate to describe some ED attendances (Masso, Bezzina, Siminski, Middleton, & Eagar, 2007).

Potential solutions offered by health care professionals were also examined. Among these solutions was patient education regarding appropriate use of health care services. Others consisted of improving the continuity of care by extending PCP office hours as well as imposing a penalty fee for those patients deemed non-urgent. A compelling suggestion was to integrate a gatekeeper in the ED who would require authorization from patients' PCPs for admission to the ED in an attempt to filter patients through or away from the ED. While some suggestions can be interpreted as biased or unreasonable because of the varying definitions of an emergency between clinicians and the patients, enhancing patient education was a mutual theme throughout the literature.

Promise of Alternative Care Sites

The ED is not the ideal health care resource for non-urgent or chronic conditions, and patients receive better care at sites capable of managing these conditions in a timely, efficient, and ethical manner (ACEP, 2011). ED costs are difficult to quantify and are most often unknown to a patient when he or she walks in. Other than knowing the standard co-pay amount for those who have private medical insurance, which can be several hundred dollars, it is impossible to determine how much the final ER bill will be

until it is received in the mail a few weeks after treatment (Fay, 2014). A cost-effective alternative to EDs for the treatment of non-life-threatening medical situations such as cuts, sprains, simple bone fractures, flus and fevers, insect bites, and infections lies in the use of alternative care sites.

ED costs correspond to the severity of a patient's illness or injury, the number of diagnostic tests and/or treatments performed, physicians' fees (typically about 20-25 percent of the total charges), radiology or specialist services, and any pharmacy or other hospital expenses (Fay, 2014). The similar services available at alternative care sites compared to ED services have proven to be substantially less costly throughout the literature. According to the Agency for Healthcare Research and Quality, average expenses for all people who had one or more visits to an ER in 2009 were $1,318 (Fay, 2014). In a study by Mehrotra, et al. (2009), the authors found that overall costs of care for episodes initiated at retail clinics were substantially lower than those of matched episodes initiated at physician offices, urgent care centers, and emergency departments ($110 vs. $166, $156, and $570, respectively). The authors compared the cost and quality of care and the delivery of preventive services for patients who received care for three conditions commonly treated in retail clinics (otitis media, pharyngitis, and urinary tract infection) with that received in physician offices, urgent care centers, and emergency departments over 1 year. The authors also recognized that the majority of provisions at these sites were administered by NPs and correlated with other studies reinforcing patient satisfaction and positive patient outcomes following care with these providers.

An Annals of Internal Medicine study found that the average 2009 cost of an ER visit for three common illnesses—middle ear infection, pharyngitis, and urinary tract infection—was $570 (Mehrotra, et. al., 2009). According to Kiplinger's Personal Finance magazine, a multi-award winning publisher of business forecasts and personal finance advice, in 2011, the average in-network cost of an emergency room visit for someone with private health insurance was about $933 (Lankford, 2010). Despite varying totals for care at each site, it is unmistakable that non-urgent care at an alternative care site is substantially cheaper than an ED visit. The most recent study discovered was a cross-sectional study performed by Caldwell, Srebotnjak, Wang, Hsia, and Zhang (2013) where they examined the charges, variability, and respective payer group for diagnosis and treatment of the 10 most common outpatient conditions presenting to the ED. The 10 most common outpatient conditions being sprains and strains, other injuries, open wounds of extremities, pregnancy, headaches, back problems, upper respiratory infections (URI), kidney stones, urinary tract infection (UTI), and intestinal infection (Figure 4). Median charges ranged from $740 for an upper respiratory infection to $3,437 for a kidney stone. The median charge for *all* 10 outpatient conditions in the ED was $1,233, with a high degree of charge variability (Caldwell et al., 2013).

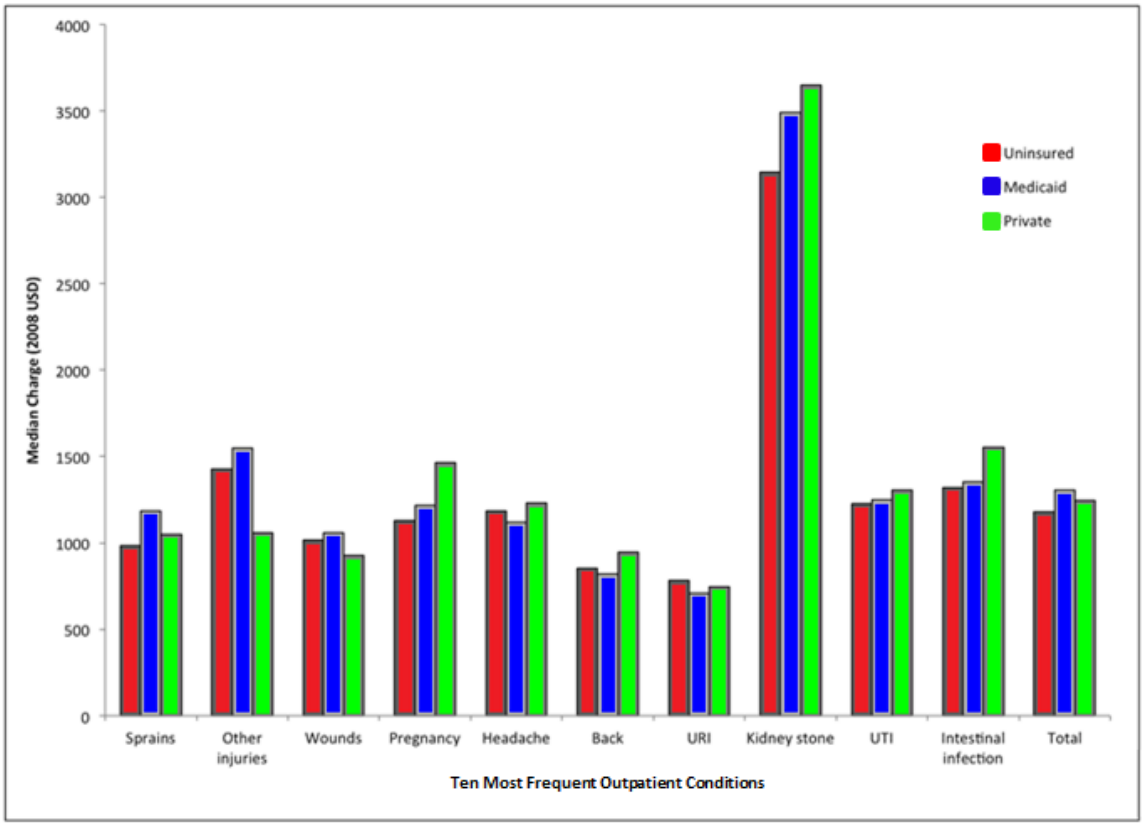

Figure 4. Emergency department charges across payer groups for the 10 most frequent outpatient conditions (Caldwell et al., 2013).

According to Ashwood et al. (2011), the 11 "retail clinic–sensitive" conditions were URIs, sinusitis, bronchitis, pharyngitis, otitis media, otitis externa, conjunctivitis, UTIs, allergic rhinitis, influenza, and unspecified viral infection, which correspond with the top-presenting complaints seen in other studies investigating ailments presenting to these alternative care site. RCs and UCCs are comparable in the spectrum of non-urgent conditions they treat and their reduced pricing. Charges for the same diagnoses were found to be 69% to 86% lower in primary care clinics than in EDs, with potentially significant savings. Reasonably, hospital margins for ED visits were much higher for emergency care than non-urgent related care ($187/patient vs. $68/visit); this finding suggests that hospitals benefit more when EDs are focused on providing emergency care

(McWilliams et al., 2011). Collectively, all studies reviewed corroborate that these alternative care sites were both appropriate for care of a non-urgent nature and less costly to all parties involved regardless of insurance status. Ultimately, the possibility of safely substituting RC or UCC care for an ED depends on the severity of the condition, the equipment and level of provider training required to care for the patient, and the patient's ability to self-triage to the most appropriate site (Weinick et al., 2010).

Summary

Both the science and practice of health care have changed dramatically over the past decades along with the role and management of EDs worldwide. Use of the ED as source for non-urgent care or primary care is episodic and fragmented yet continues to occur. Additionally, with the uninsured and insured populations misusing the ED equally, an ominous tension in placed on the safety net of the health care system. With RCs and UCCs commonly being operated by NPs as principal providers, the potential benefits of more useful utilization of these sites by patients seeking non-urgent care carries twofold gains for improved patient outcomes and employment opportunities for NPs. Reducing the educational deficit of these individuals may help to improve the misuse of the ED.

SECTION THREE:

METHODS

Introduction

The purpose of this project was to educate lower acuity patients after discharge from the ED on use of alternative care sites, such as RCs and UCCs, for future non-urgent complains. Taking place at a single ED in Miami Dade County, FL the implementation of a Discharge Alternative Non-urgent Care Education (D.A.N.C.E) protocol to address the misuse of the ED was chosen for this project. Enhancing the individual's knowledge of available alternative care sites, and assessing the protocol's influence on future decisions to use these sites, is central to the study and could be instrumental in future health care reform.

Design

A descriptive post survey design was chosen for this project with a cross-sectional pilot intervention by use of the D.A.N.C.E protocol on lower acuity patients presenting the ED. A descriptive project is one in which information is collected without changing the environment. This design was chosen because descriptive studies can yield rich data on the naturally occurring health status and behavior of a particular group that could lead to important recommendations in practice. A pilot design was selected, as these are small, preliminary clinical projects whose primary objective is to prove that further studies need to be done.

Setting

The setting for this project was a single ED in Miami-Dade County, FL open 24 hours a day and 7 days a week. The department is professionally staffed with emergency department physicians (EDPs), nurse practitioners (NPs), physician-assistants (PAs), and registered nurses (RNs). The average amount of patients seen in this ED on a given shift is over 100 patients, with a shift equating to 12 hours. Provisions for lower acuity patients are primarily under the direction of an NP or PA with higher acuity patients being under the care of an EDP. Provider designation can also be dependent on patient volumes and provider work hours. EDPs usually are on shift from 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. in this ED, with PAs and NPs on duty between 9 a.m. to 9 p.m. and/or 3 p.m. to 3 a.m., respectively. After 3 a.m. all patients, regardless of acuity level designation, are under the care of the EDPs. The primary languages spoken by the patients who presented to this hospital during the implementation of this project were English followed by Spanish.

Project Phases

The project progressed through four phases.

Phase One: The Protocol

The D.A.N.C.E. protocol was implemented in a pilot project with the use of an educational protocol constructed from national evidence-based data on the scope of care available at non-urgent care sites and the ED. An exhaustive appraisal of accredited medical and nursing agencies as well as insurance companies' data was reviewed during

the constructing of the D.A.N.C.E. protocol. Studies performed in the past that examined the non-urgent use of the ED the statistical data of the most commonly sought and treated complaints in the ED was also reviewed and utilized in the construction of the protocol. A single-page protocol was drafted to represent the data collectively and concisely. All symptoms and conditions listed on the protocol pertaining to non-urgent complaints could be cared for at local UCCs and RCs. In attempt to refrain from prolonging physical length of stay in the ED, which differs from the length of stay (LOS) documented by health care facilities, the protocol and survey card were tailored to be brief yet effective. Face validity was then established by a staff consensus panel.

Phase Two: The Consensus Panel

The consensus panel consisted of five ED health care providers from the selected facility who met inclusion criteria to participate. A meeting date and time were determined after all members had accepted to contribute to the project. Each panel member was provided with a cover letter describing the project and the role expected of the panel member. The D.A.N.C.E protocol and survey was then provided to the consensus panel for review of face validity. A review of the information on the protocol took place in a face-to-face workshop in the ED conference room of the selected facility over a 2-hour time period with all members of the panel present. Face validity was determined by the panel as they reviewed the protocol based on professional practice experiences, relevance, readability, and population characteristics seen and treated in this ED. The overall appearance of the protocol and survey card was appraised by the panel

as well. Panel commentary was considered for future revisions of the project and will be discussed further in the Results section of this project.

Phase Three: D.A.N.C.E Protocol Pilot

The D.A.N.C.E protocol and survey card (Appendix E) were offered to lower acuity patients after their complete discharge from the ED. The protocol was available in English and Spanish. Translating services were employed (Appendix F) and included back-translation, in which all text was translated into another language then translated back in the first language to ensure that it equated so that results could be compared. The protocol was administered individual by individual after discharge from the ED. Along with the protocol, a cover letter introducing the project as well as an explanation of voluntary involvement was attached for the patient's review. The DNP student also provided each participant with a short verbal introduction to the project, which included explanation of voluntary involvement, a brief personal introduction of the DNP student, navigation of the protocol, and instructions upon completion of survey card. This was the only involvement the DNP student had with each participant in efforts to enhance comprehension of protocol's aim. It was expected that the protocol would not take more than 10 minutes to complete; nevertheless, each participant was allotted individual time with the protocol for review after their complete discharge from the ED.

At the completion of the patient's review of the protocol, a survey card was completed by each participant. Participants were free to review the protocol and complete the survey card anywhere on hospital premises. A locked drop box was visibly located at the front desk of the ED waiting area for collection of the surveys. Only cards

returned to the drop box were included in the analysis at the completion of the project. At the completion of the visit and project participation, each participant was allowed to take the educational protocol home for further review and future use.

Phase Four: Data Analysis

In order to analyze the D.A.N.C.E. protocol's effectiveness and influence on the patient's health-seeking decisions, a post intervention survey card was utilized. The survey card consisted of two questions. The first question being, *Where would you seek care next time you have the same or similar health care problem?* followed by four checkboxes listing *The Emergency Room, Urgent Care Center/Retail Clinic,* and *Primary Care Provider* as options for selection. Participants were asked to select one of these options from the list. The second question was *Did the D.A.N.C.E. protocol help you make your choice above?* followed by checkboxes indicating *Yes* or *No*. Participants were again asked to only select one option from the list of possible response. The date and time were also included on the survey card. Evaluating a post intervention survey card for the protocol's influence on care seeking decisions may help guide policy changes in determining what interventions need to be made when catering to the health care needs of this community. Further discussion on this concept can be found in the Results section of this project.

Sample

The sample obtained for the consensus panel were those ED staff members who met inclusion criteria and volunteered their involvement in the project. A flyer created

by the DNP student (Appendix G) was posted in the ED employee lounge area and other employees-only areas announcing the project and inviting those who met inclusion criteria to participate in and/or inquire about the project. The target sample size for this consensus panel was a minimum of three and a maximum of five staff members. The first five staff members who met inclusion criteria to accept involvement in the project formed the consensus panel. All inquiries from prospective participants were addressed as they were received by the DNP student and as needed by each member throughout the project in order to maintain full disclosure of the requirements of each panel member.

A convenience sampling technique was used in the selection of patient participants arriving by their own means to the ED, deemed non-urgent based on ESI acuity level, and met inclusion criteria. A flyer created by the DNP student (Appendix H) was posted throughout the ED discharge area announcing the project and inviting those who met inclusion criteria to participate in and/or inquire about the project. The D.A.N.C.E protocol was distributed to individuals who met inclusion criteria after all hospital documentation had been completed and all care provisions had been administered. The target sample size for this portion of project was approximately 20 patient participants. It was felt by the DNP student that this sample size was large enough to provide useful information about the aspects that were being assessed at this stage of the project, as had been demonstrated in similar pilot projects on this area of study.

The Emergency Severity Index (ESI) acuity level is used at this facility. If a patient does not meet high acuity level criteria (ESI level 1 or 2), the triage nurse then evaluates expected resource needed to help determine a lower acuity designation level

(ESI level 3, 4, or 5). Generally, ESI level 4 or 5 conditions are those that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration. Based on composite review of current literature, the interventions for some of these illnesses or injuries could be delayed or even referred to other area of the hospital or health care system. Sample participants in this project were selected based on the assignment of acuity established by the ED RN assessment with a designation of an ESI level of 4 or 5, indicating lower acuity. It is important to note that because ESI levels incorporate both objective and subjective patient findings, the ESI number designation can change after certain immediate, non-life-saving provisions are provided to enhance the patient's overall comfort and health state (e.g., an ice pack for a minor limb injury). For this reason, in the event of an insufficient amount of participants, some ESI level acuity 3 patients qualified for this project. As a result, the DNP student considered the expertise of the RN involved in the triage, direct care, and discharge of the patient in order to verify the patient's qualification for the project. Providing the protocol at the end of the ED visit allowed for better identification of qualifying patients and the decision to include ESI level 3 patients.

Inclusion Criteria

Requirements to participate on the consensus panel included voluntary involvement, educational level of a Master's degree in health care (e.g. nursing and/or medicine) or higher, and/or a minimum of 5 years of emergency room and/or urgent care center experience. Current employment in the emergency department at the participating facility was also required.

Inclusion criteria for pilot project participation included being a patient discharged from the ED on the day the project was implemented, ESI acuity level 4 or 5 (some ESI level 3 were considered), and English and/or Spanish speaking individuals. The project only included patients 18-64 years of age. As mentioned in the review of literature, this age group was found to frequently misuse the ED for non-urgent complaints. Voluntary involvement was also required of D.A.N.C.E. pilot project participants.

Exclusion Criteria

Exclusion criteria for the staff consensus panel included employees who did not meet any of the inclusion criteria.

Exclusion criteria for pilot project participation included patients younger than 18 years of age and older than 64 years of age. Patients suspected to be intoxicated as well as patients with cognitive disabilities involving comprehension and expression of clear thought, whether or not related to their reason for the visit, were also excluded. Languages other than English and/or Spanish were not included in this project due to limited availability of translation of the protocol in more than one foreign language and time constraints. Any person suspected to be a victim of abuse or any person who presented as part of hospital required ED evaluation (such as employees or prisoners) were excluded to avoid interference with legally required documentation and policies. Patients who as a result of their visit were admitted to the hospital were also excluded as their condition warranted the use of ED and later inpatient services. Patients who were referred to the ED from an alternative care site for further evaluation were excluded along

with patients who were told by a provider at this facility to return to the ED for follow-up care. Patients who received a protocol but did not wish to complete a survey card were excluded due to partial participation. Finally, any participants who refused to volunteer were excluded for obvious reasons. All patient participants were allowed to keep the protocol for future use regardless of participation level after recruitment.

Protection of Human Subjects

Protection of human subjects was incorporated and maintained throughout the entirety of this project. Prior to data collection, the Institutional Review Board of Barry University approved the project as an exempt project (Appendix A). Also prior to data collection, the Institutional Review Board of the local hospital in which the pilot project took place also approved this project as exempt (Appendix B).

Each panel member received a cover letter identifying him or her as an official member of the consensus panel as well as describing his or her role in the project (Appendix C). Panel members were informed that any information provided would be kept confidential—that is, no names or other identifiers were collected on any of the instruments used during this project. Any discussion or revisions made to the protocol were maintained by only the DNP student. This project was of minimal risk. There may have be some anxiety about establishing face-validity of a protocol that would be distributed to patients for educational purposes for each member of the consensus panel. This risk was minimized through voluntary involvement and face-to-face dialogue on material allowing for open discussion that did not harm subjects. There was no direct benefit or compensation to the members of the consensus panel for participating in the

educational project. Panel members may have gained awareness of patient's health-seeking behaviors including the patient's increased awareness of alternate care sites and emergency departments by participating in this project.

A cover letter for patient participants (Appendix D) was attached to each D.A.N.C.E protocol introducing the project as well explaining voluntary involvement. No patient identifiers were collected during the project to preserve patient privacy. It is also important to note that the DNP student did not have access to any participants' medical records or ED charting for this project. There may have also been some anxiety for the patient participants about completing the protocol. This risk was minimized through voluntary involvement, anonymity of responses, and the use of non-invasive project processes that did not harm subjects. Patient participants were made aware that, although unlikely, should they experience overwhelming anxiety related to being in this project, they were welcome leave the project at any time and use the ED or a care site of their choice, to treat this anxiety.

All participants, staff and patient, were asked to not provide any identifiable information including but not limited to name, age, or sex on the forms collected. During the collection of data, all information and documents were kept in a locked locker, which was only accessible by the DNP student and was located at the selected facility. Any information provided electronically was kept on a password-protected computer system, which was also only accessible by the DNP student, at the selected facility. All collected data is to remain kept in a locked cabinet at the home of the DNP student for a minimum of 5 years and will only be accessible by the DNP student.

Data Collection Methods

Data collection took place at a single facility within a large health care system. The management team was notified of the project's time frame through a series of emails and meetings detailing ED staff and patient involvement. ED staff was then notified of the project and its aim through pre-start-of-shift-huddle announcements. Panel members were recruited approximately 1 week prior to the collection of survey cards from the D.A.N.C.E. protocol pilot. This time frame allowed for adequate review of the protocol and any cosmetic changes to be done to the document if needed. No formal notes were documented at this workshop; however, comments and suggestions were considered for future study. These ideas and recommendations are discussed further in the Results section of this project.

Patient participants were recruited between the hours of 9 a.m. to 9 p.m. on one date. Due to the hours of operation of the ED selected, the DNP student distributed the D.A.N.C.E protocol after the complete discharge of the patient from the ED between the hours of 9 a.m. to 11 a.m. in the main area of the ED. After 11 a.m., recruitment took place from within the section of this ED titled the Rapid Care Unit (RCU). This area is involved in the care of non-urgent patients that present to the ED and is staffed by a single RN and ED technician as well as an NP or PA. Patients are seen in this separate area of the ED after being deemed non-urgent by the triage RN. This area was created by this facility in response to an increase of lower acuity patients presenting to the ED; its aim is to free rooms in the main ED for higher acuity patients. The secure drop box was made available to participants until 9:30 p.m. for convenience and allowance of protocol review. This time frame was chosen, as it is considered one of the peak hours of

operation in this ED. The protocol was provided after complete discharge from the ED in efforts to avoid patient sentiment involving discrimination or singling out for project participation. Furthermore, post-discharge intervention was chosen in efforts to avoid patient's viewing participation as an impediment or delay to care.

Outcomes Measures

Each objective of this four-phase project was evaluated following the procedures in Phases One through Four. The measure of meeting these objectives was defined for each objective:

1. To present a draft of the D.A.N.C.E. educational tool, constructed from national evidence-based data on services available at non-urgent care sites and the emergency department to a consensus panel for review of face validity
2. To initiate a pilot project of the D.A.N.C.E. protocol over a 1-day period at a local hospital to evaluate the protocol's effectiveness
3. To describe the D.A.N.C.E. protocol's influence on the patient's future decision to use an alternative care site over the ED for the same or similar complaint by evaluating the post intervention survey cards completed by the patients. The survey cards will be reviewed and analyzed to determine the feasibly of such a protocol implementation in the future and possibly on a system-wide level. The Results section of this final project explains this concept further.

Proposed Budget

The cost of this project was $453.58. The cost was allotted to the printing cost of 50 copies of the three-page protocol including the cover letter, protocol, and survey card in both languages (100 copies total) as well as the cost of the locked drop box. Translator and editing services were also aggregated to this total.

Summary

This section discussed the methodologies of the project. As the United States population continues to grow, so will the strain on our health care resources if a fundamental redesign of our nation's health care provisions is not addressed appropriately. An advent to the expanding population is the rise in scientific inquiry to determine innovative methods to improve health care. Alternative care sites may potentiate this impetus as more tactful utilization of health care resources is part of the solution to alleviate ED misuse. In order for non-urgent care to be sought at a reciprocal site, patients must be made aware of the valuable resources these clinics and centers offer and when to use them.

SECTION FOUR:

RESULTS AND DISCUSSIONS

Introduction

The aim of this project was to increase awareness among lower acuity patients presenting to the ED with non-urgent complaints of the care and services provided by alternative care sites. The D.A.N.C.E. educational protocol, constructed from national evidence-based data on services available at non-urgent care sites and the emergency department, was presented to a consensus panel for review of face validity. With the use of the D.A.N.C.E. protocol, lower acuity patients (ESI acuity level 4 and/or 5) were presented with the single-page protocol for review and a post intervention survey card examining the protocol's influence on future decisions. The setting was a local South Florida ED in Miami Dade County, FL, and surveys were collected on a single day between the hours of 9 a.m. to 9 p.m. Results from the study were analyzed by the DNP student, with percentage calculations performed in and displayed graphically with the use of Excel spreadsheet.

Findings

Overall, project objectives were met at the competition of the project. While the findings were not expected, project aims were performed and delivered as intended. Thankfully, there were no adverse events associated with this project. The findings will be discussed through each phase of the project.

Phase One: The Protocol

The primary objective of Phase One was to construct an educational protocol from national evidence-based data on the scope of care available at alternative care sites and the ED. The single-page educational protocol listed common illness and conditions that could be treated at alternative care sites on the left side of the paper and reasons to call 9-1-1 or seek care in the ED on the right. The protocol also included visual aids such as small icons depicting each of the common illness and conditions listed for the alternative care site side. A short narrative was included at the bottom section of the page depicting ED flow based on severity and the comparable benefits these alternative sites offer. With information obtained from reputable sources such as: Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), major United States insurance companies, consumer reports, health care analyst writers, and similar scholarly works on the topic, the objective to construction the D.A.N.C.E. protocol was accomplished.

Phase Two: The Consensus Panel

The objective in this phase was to present the protocol to a staff consensus panel for review and face validity. After initiating the recruitment process with flyers in the ED employee areas, the final panel consisted of five nursing professionals. This consensus panel consisted of: one RN with a Master's of Science in nursing (MSN) in education and 9 years of ED nursing experience; one RN with an MSN and 8 years of ED nursing experience; one RN with a Bachelor's of Science in Nursing (BSN) but 10 years of ED nursing experience; one RN with a BSN and enrolled in her third year of a Doctorate of

Nursing Practice (DNP) program but with 7 years of ED nursing experience; and one NP with a Doctor of Philosophy (PhD) in Nursing and 10 years total of nursing experience with 6 years of ED nursing experience and 4 years of UCC experience. The all RN staff consensus panel is represented in the table below (Table 2). The protocol was overall accepted by the group, and face validity was established fairly quickly. After further review, the panel agreed that the protocol maybe too wordy, and this may deter participants from reading it entirely. Other suggestions from the panel included that more distinguishing images of what are considered an emergency could potentially help drive the protocol's point more effectively. The panel also suggested that a future version include this health system's alternative care site addresses on the protocol so the patient can have these readily available. Ultimately, face validity was established by the staff consensus panel, meeting the objective for this phase. It is interesting to note that there was a unanimous agreement in that the project had merit and boundless potential for future investigations into health care changes after the establishment of face validity.

Table 1 *The Consensus Panel*

Consensus Panel	Education Level	Years of Experience ED/UCC
Member 1	MSN	9 yrs (ED)
Member 2	MSN	8 yrs (ED)
Member 3	BSN	10 yrs (ED)
Member 4	BSN	7 yrs (ED)
Member 5	PhD	6 yrs (ED)/ 4 yrs (UCC)

Phase Three: D.A.N.C.E Protocol Pilot

The main objective of this phase was to initiate a pilot test of the D.A.N.C.E. protocol over a 1-day period at a local hospital to evaluate the effectiveness of the protocol. Regular hospital services were provided throughout the patient's emergency department visit by the ED staff prior to participant involvement in the project. At the request of the selected facility, the DNP student scripted a brief narrative for the primary ED RN and the ED Patient Care Supervisor to follow if their involvement was needed in the study. This script, brief in length and available in English and Spanish, only introduced the DNP student and assessed the patient's initial willingness to participate in the project. The RN assigned to the RCU area on the day of the project utilized the scripting with no difficulties. Overall, there was a receptive and cooperative welcoming of the protocol and survey collection process from the ED and RCU staff.

After discharge from the RCU area, participants were recruited as they exited back into the ED waiting area. Each potential participant was asked to participate and informed that he or she could complete the survey anywhere on the hospital premises and return the card to the drop box in the ED waiting room area. All patients completed the survey in the ED waiting room area. On average, each participant took approximately 5 to 10 minutes reviewing the protocol and completing the survey card. All participants were admittedly open to the prospect of the doctoral work being conducted, and several comments were volunteered by participants during the project to the DNP student. These comments and their implications are discussed in further detail in the section titled Patient Observations of this final project. A total of 23 surveys were collected by the end of the day. Of these 23 surveys, only 22 were included in the final analysis due to

multiple answers being selected in question one on one survey collected. Exceeding the sample size of a minimum of 20 participants, the main objective of this phase was met. The following table depicts the final tally of surveys completed:

Table 2.

D.A.N.C.E. Protocol Pilot Results

Care Site Options	D.A.N.C.E. Protocol Influence	
	Yes	No
Emergency Room	11	1
Urgent Care/Retail Clinic	8	0
Primary Care Provider	1	1
	20	2

Phase Four: Data Analysis

The primary objective of this phase was to analyze the D.A.N.C.E. protocol's survey results and describe its influence on future care site decisions made by the patients. This objective was met by use of percentage calculations in an Excel spreadsheet to analyze the survey results. After evaluating the post intervention survey cards, the protocol was found to have significant influence over a future care site choice; however, the care site itself seemed to remain at the discretion of the patient. Of the 22 completed surveys returned, 55% (12) selected the ED, 36% (8) selected RC/UCC, and 9% (2) selected their PCP as the future care site for the same or similar complaint as reported on the day of the pilot project. The majority of the surveys showed that 91% (20) of the participants found the protocol influential, and 9% (2) selected the protocol had no influence on their future care site decision. Results from each question were calculated separately and are represented graphically below:

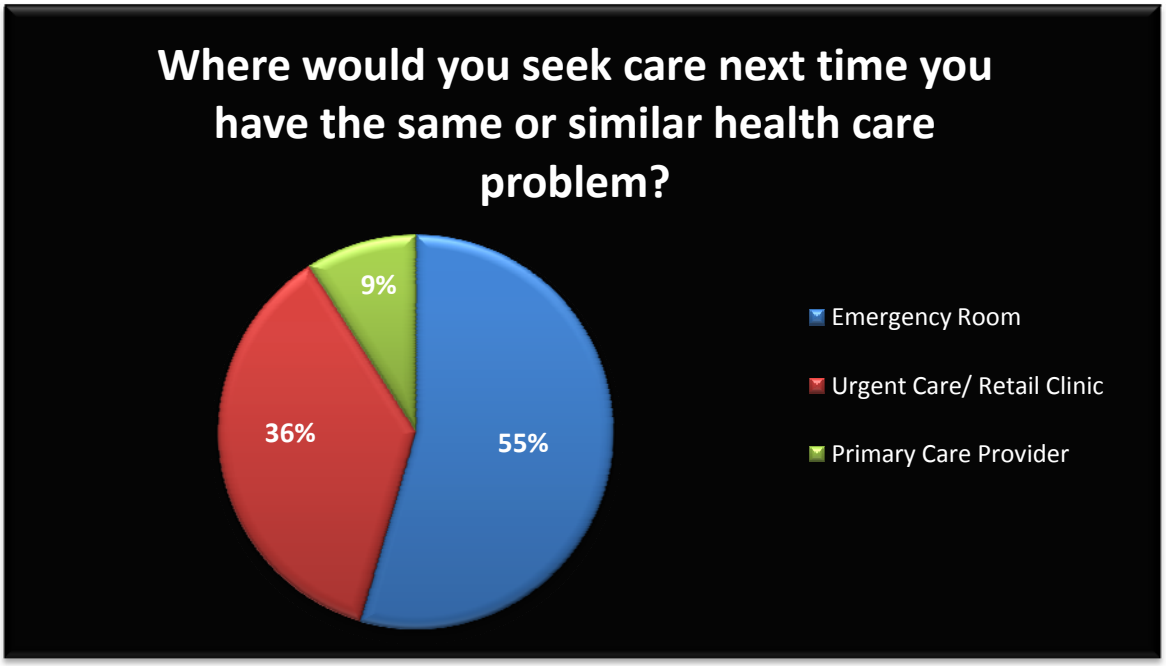

Figure 5. D.A.N.C.E. protocol pilot survey results: Question #1.

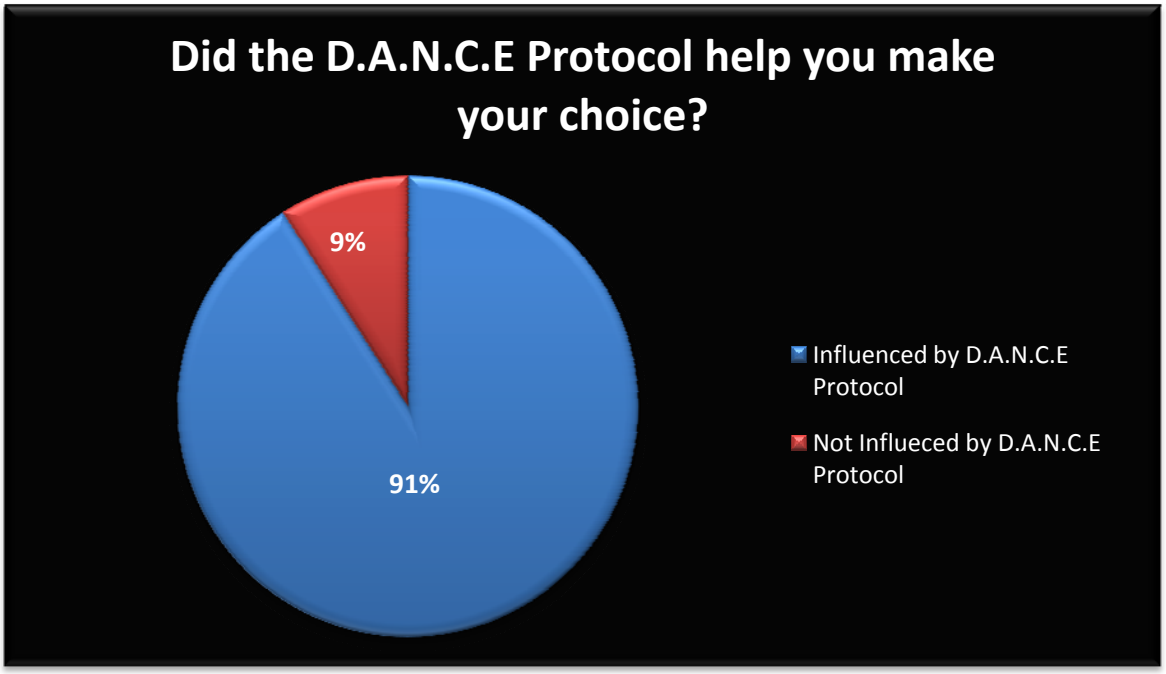

Figure 6. D.A.N.C.E. protocol pilot survey results: Question #2.

Discussion

It was expected that the D.A.N.C.E. protocol would influence patients to choose an alternative care site over the ED in the future for the same or similar non-urgent complaint. Results of this project show that future care site choice incorporates more than a knowledge deficit of available care sites. Despite more than half of the patients selecting the ED as their next potential source of non-urgent care, a post discharge intervention did seem to influence future care site selection. Of the patients surveyed in this project, it stands to reason that 45% of these patients can be and are willing to be treated for their non-urgent complaints elsewhere. Applying these results to a larger scale, an argument can be made that of an estimated 1,000 patients arriving to an ED with a non-urgent complaint, 450 of those patients could be treated at an alternative care site. Moreover, 910 of those 1,000 patients would choose the alternative care site having been influenced by the protocol. This finding is especially significant when savings on health care resources and finances are factored into these calculations as well.

These results effectively answer the project questions. Recall from Section One, these project questions were: *Will the D.A.N.C.E. protocol affect patient health-seeking behavior when determining appropriate care sites for non-urgent, lower acuity health complains?* and *What is the likelihood the D.A.N.C.E. protocol can be an effective educational protocol on a system wide level to reduce the misuse and overcrowding of the Emergency Department by non-urgent patients?*. Based on the survey results, a post discharge intervention did seem to influence future care site selection however it appears that modification of the information on the protocol may be required in order for an appropriate and reciprocal site to be chosen and better address the needs of these patients.

While a future system-wide protocol does appear to be promising, there were several factors and significant limitations that presented during this project that require further examination in order to determine the feasibly of implementing such a protocol on a system-wide level. Among these inquiries, a financial analysis of the expenditures of the project date on the treatment of these non-urgent patients in the ED may be useful as well as investigation of annual costs for the treatment of these patients at this particular hospital.

Strengths and Limitations of the Project

Despite the limitations identified, the project findings did reinforce and build on existing investigation found on non-urgent use and misuse of the ED. The main strengths and limitations found are addressed below.

Sample Size

At the request of the selected facility, the minimum sample size was kept at 20 participants, but a maximum sample size of 50 participants was added to the project. Due to time constraints in executing this project, a small sample size was achieved. It was recognized by the DNP student that the sample size, although sufficient for a pilot project, may have benefited from reaching the larger sample target. Although the final sample size was found to be reproducible and applicable on larger scale, a small sample size may not serve as a total representation of these non-urgent patients and impacts the ability to generalize these findings to other EDs, populations, and health care systems. Moreover, as in any survey, results are subject to sampling and non-sampling errors.

Non-sampling errors include reporting and processing errors as well as biases due to nonresponse and incomplete response. Only 22 of the 23 surveys returned were completed correctly, so the already small sample size results were affected pointedly even by the one error. Another significant limitation was that despite a growing volume of patients, this facility, being the newest of the hospitals within this health care system, has yet to meet a consistently large minimum number of patients seen daily through the ED as its counterparts have. The reported total number of patients seen this day was 217, per the management team. Therefore, the sample size reached during the project represents only 10% of the population seen in the ED that day. Thus, an assertive sample size was difficult to predict. However, because of the unpredictability in patient volume at this facility, there is weakened defense against the sample size obtained not being sufficient to generalize.

Project Setting

The facility in this project is the current place of employment for the DNP student. This facility was chosen for its convenience as well as for the organization's renowned enthusiasm to participate in and improve nursing research efforts. This interest in nursing inquiry paired with the system's backing for advancement of the nursing profession, has resulted in the overall improvement of patient care for this health care system in the four years of its existence. With the facility being the newest hospital to be built in South Florida for over 30 years and the youngest of the hospitals within this health care system, its appeal to the public maybe clouded by its innovation instead of its services and capacities. Additionally, this health care system is partnered with a

performance improvement company that focuses on the overall patient experience and satisfaction with care. As a result, customer service plays a large role in delivery of care within this health care system, as patient satisfaction scores dictate certain allocations of funds for the staff and department. While ideal for the patients, once again, the facility's organization and novelty may have created a bias in the patients' decisions on where to seek care.

Another limitation realized was the established RCU area in this ED from 11 a.m. to 11 p.m. Due to the growing number of non-urgent patients presenting to this ED over the 4 years it has been open, this area was created approximately 2 years ago in effort to decompress an overcrowded main ED. Although this area served as an advantage to the project for lower acuity patient selection, the established rapid care area seemed to have gained fame among the lower acuity patients, as many were aware that they could be seen faster in this ED because of this area. With patients being unable to differentiate the services being provided by the RCU as services that could be received at alternative care sites, conducting the protocol pilot in this area may have stirred confusion among participants. Finally, the health care system selected currently operates a number of UCCs throughout Miami Dade County, and although not explicitly included, directly mentioned or favored in this project, these UCCs were often referred to by patients as an interchangeable name for alternative care sites. This instinctive substitution of the word presented an additional bias to the project for participants.

The D.A.N.C.E. Protocol

A strength in the project was that the protocol itself was generally well accepted, visually appealing, and easy to navigate. The survey card's succinctness was also a strength as patient engagement was easier to maintain with a brief and simple survey. The consensus panel, however, did note some limitations of the protocol. One of these limitations was that the narrative portion located at the bottom section of the protocol may have been visually daunting for some participants, especially when health care literacy was considered. It was also found that the icons depicting common alternative care site conditions may not have conveyed the difference in severity. The panel recommended visual representation for the ED portion of the protocol, within reason and censorship, to better distinguish the differences in severity. Interestingly, both the panel and some patients recommended that the addresses to local alternative care site be included on the protocol. Although the protocol and survey card were well received by the panel and patients alike, the results of the survey lead the DNP student to believe that there was a disconnect between the participants recognizing the relationship between the two questions on the survey card. This conclusion was drawn after multiple observations were volunteered by participants during the pilot project.

A final limitation of the protocol was the limited data gathered. With no demographic data collected, such as age, sex, ethnicity or racial group, level of education, socioeconomic status, generational or immigrant status and/or disability status, there was no real method of truly defining this population. Similarly useful would have been topic-specific characteristics like achievement level or retainment level of information in this educational intervention. These characteristics can serve as important elements to

understand of the nature of the sample and the degree to which the results can be generalized to other EDs, populations, and health care systems. Collection and evaluation of these characteristics could also prove to be useful in meta-analytic studies that could incorporate this project's results.

Patient Observations

Bonus insight from the project was found in patient observations while interacting with them after their completion of the survey. Many were intrigued by the scholarly work and asked questions about the function and role of an NP and, moreover, a DNP. Many recognized and applauded the aim of the project stating that the protocol was seemingly influential on future use; however, many of those same patients recognized that their complaints were not life-threating but would still choose this ED over an alternative care site. Other comments showcased that an educational deficit had less to do with care site choice and more to do with personal preference and convenience. Several patients commented that they would gladly fill out a survey because of their adoration for this facility and that they would always return to it for care. Others commented on how they do not like the customer service at the local UCCs and prefer this ED. Other participants mentioned that they prefer the hospital because is close to their home. One patient commented that he had not been in this country for more than 16 days, did not know how the health care system works, and did not know of anywhere else to go for health care treatment. Another participant refused to participate as he simply wanted to leave in order to fill the prescriptions as soon as possible. Interestingly, a recurrent comment made by several participants was their lack of a PCP as well as a lack

of trust in their established PCP. Anecdotal evidence suggests that lack of insurance or changes in insurance is responsible for this factor however; more investigation would have to take place to determine this. Finally, multiple patients commented that this ED is fast compared to the other EDs in this health care system, and the staff is always pleasant. It is important to note that no patient observations were documented in any form during the project pilot. These observations provided insight on several limitations to project regarding personal preference when choosing care sites. They also point to factors that drive decisions to seek care that are multifaceted and fall beyond an educational deficit.

Implications of the Project

The consistent delivery of appropriate patient care requires a fundamental reordering of priorities and redesign in the delivery of health care in order to be more efficient. Nursing as a practice profession requires both practice experts and nurse scientists to expand the scientific basis for patient care. Doctoral education in nursing is designed to prepare nurses for the highest level of leadership in practice and scientific inquiry (AACN, 2006). DNP projects focus heavily on practice that is innovative and evidence-based, reflecting the application of credible research findings. This project proved to be significant in the areas of nursing, specifically the DNP Essentials, as well as in practice, health care delivery, health care outcomes, and health care policy.

DNP Essentials

Doctoral education, whether practice or research, is distinguished by the completion of a specific project that demonstrates synthesis of the student's work and

lays the groundwork for future scholarship (AACN, 2006). The completion of this change initiative, presented as a pilot project, embodies this expectation. Major advantages of the DNP-prepared nurse include the enhanced focus on providing requisite specialty knowledge and care for patients across the spectrum and playing a pivotal role in the larger health care system. While all doctoral nursing graduates demonstrate the competencies delineated in DNP Essentials I through VIII, further DNP preparation falls into two general categories: roles that specialize as an advanced practice nurse with a focus on care of individuals and roles that specialize in practice at an aggregate, systems, or organizational level (AACN, 2006). As previously discussed in Section One, the DNP Essentials document outlines and defines the eight foundational Essentials and provides some introductory comments on specialty competencies/content. Examining the results, it is evident that the Essentials are embedded throughout the project.

Essential I: Scientific Underpinnings for Practice is apparent in project's approach to scientific inquiry and in the topic being examined. By use of scientific theories and procedures, the project successfully examines a population's health-seeking behaviors and knowledge deficits in awareness of the role of alternative care sites for non-urgent healthcare complaints. The project showcases the development and evaluation of new practice approaches based on nursing theories as well as theories from other disciplines and in doing so successfully incorporates this essential.

The expectations of *Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking*, were met through the project aim, which was implementing an educational protocol that enhances public's knowledge of available alternative sites more appropriate for care. The project effectively develops and

evaluates a care delivery approach to meet the current and future needs of a population based on scientific findings in nursing, as well as organizational science. The results of this project can be further explored to more firmly address ethical, financial and quality improvement issues surrounding the improper use of the ED.

With the focus of *Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice* being on the translation of new science, its application, and evaluation, the project affirmatively generates evidence through practice to guide improvements in practice and outcomes of care. The implementation of this project and its results showcase the DNP student's ability to use analytic methods to critically appraise existing literature on a current issue in healthcare. In conducting this project, the DNP student applied relevant findings to develop a potential practice protocol that could ultimately improve practice and care.

Under *Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care*, the project allowed for the DNP student to design, use, and evaluate a protocol that serves to assess consumer use of health care information and health seeking behaviors. Through this project, analysis and identification of significant elements involved in patient's health-seeking behaviors were examined and the results hold potential for further study on the use of patient care technology and how it relates to their healthcare decisions.

Perhaps most evident in the project, *Essential V: Health Care Policy for Advocacy in Health Care* was demonstrated as policy development and creating a health care system that meets the needs of its constituents was central to the project. This is evident by the abundant potential the results yield that can be used to educate others,

including policy makers, regarding nursing, health policy, patient care outcomes, and related issues from the perspective of consumers in health care.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes stresses the importance of effective communication and collaborative skills in the development and implementation of practice models, peer review, practice guidelines, health policy, standards of care, and/or other scholarly products (AACN, 2006). The project showcased a collegiality among a community of highly skilled and knowledgeable individuals from multiple professions of the health care system in attempts to better serve a population and utilize health care resources as effectively as possible.

Under *Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health,* the DNP is expected to evaluate care delivery models and/or strategies using concepts related to community, environment and occupational health, and cultural and socioeconomic dimensions of health (AACN, 2006). The project serves to identify and examine health seeking behaviors and its results provide an array of possible further exploration of these choices. The project embraces the community and adds to the current body of knowledge supporting strategies aimed at improving all dimensions of health. Overall the project's aim points to improving the general health of the nation overtime with the implementation of a refined system wide protocol in the future.

Lastly, *Essential VIII Advanced Nursing Practice* was evident throughout the entirety of the project. Focused on the already established strengths of the NP, the project showcases the ability of the DNP student to demonstrate advanced levels of clinical judgment, systems thinking, and accountability in designing, delivering, and

evaluating evidence-based care to improve patient outcomes. The DNP student's conceptual and analytical skills in evaluating the links between practice, organizational, population, fiscal, and policy issues is fundamental to the project; these skills are the essence of advanced nursing practice. Overall, this project serves as an example of advanced understanding in a group of individuals as well as platform for future practice reform and system change. The project also supports the concept of NPs functioning as assets to our shifting health care system as they enter greater roles as DNPs.

Implications for Practice

The theme that links scholarly experiences is the use of evidence to improve either practice or patient outcomes (AACN, 2006). As our health care system shifts to accommodate the needs of a rapidly growing nation and different areas of health care accept NPs as key stakeholders in the provision of quality care, alternative care sites present a promising opportunity for NPs. Well suited to care for the majority of patients with non-urgent problems, the project extends and reinforces the compelling evidence to suggest that increasing the use of NPs in other realms of the health care system may be advantageous and profitable. With the expansion of advance nursing education to a doctoral level, DNP-prepared nurses demonstrate a progressive and profound knowledge in practice that serves as an impressive asset in translating and redefining advance nursing practice.

Implications for Health Care Delivery

This project serves as a novel and targeted intervention necessary in the face of a much-needed redesign in the delivery of health care. With the project results indicating that a post-discharge intervention can influence an individual's future care site decision, the delivery of health care can focus on more tactful utilization of resources through similar protocols. Additional study must first be conducted in order to properly address the multifactorial causes of ED misuse. With the advent of NPs working and flourishing in many of these alternative care sites, the project served as a practical starting point for NPs to lead scientific actions geared at addressing this population's health care needs and improving the overall delivery of health care.

Implication for Health Care Outcomes

The results of this study potentially prove that educational deficit is only a partial motive in selecting the ED for non-urgent care. The patient's ability to self-triage to the most appropriate care site fundamentally impacts health care outcomes. The project validates this and has determined that interventions require additional modification. Tailoring interventions to the individual is among one of the many advantages the NP's astute clinical judgment and evaluation. This advanced understanding of individual needs as they relate to the community assists in improving health care outcomes and affects the overall health care system. The implementation of a discharge educational protocol has apparent influence over individuals' care site choices. Applying this finding, NPs should design and utilize such protocols when tailoring interventions geared toward care non-urgent complains. Implementing such a protocol can prompt patients to

seek care accordingly based on their level of acuity and resources required to care for them. The proper application of provision will affect the dynamics of health care, which will, in turn, positively affect health care outcomes.

Implications for Health Care Policy

Health care policy—whether it is created through governmental actions, institutional decision making, or organizational standards—creates a framework that can facilitate or impede the delivery of health care services or the ability of the provider to engage in practice to address health care needs (AACN, 2006). This project demonstrates engagement in the process of policy development by creating a change initiative to meet the demands of the health care system and the needs of its constituents. From the inception to completion of this project, the DNP student servers as a leader in the practice arena and provides a critical interface between practice, translation of research, and policy. Evolving in health care as a key element to reform, NPs are rapidly being placed at the political forefront to policy changes that embrace better care options for patients. Involvement in this project provides the DNP student with essential competencies to assume a leadership role in the development of health policy as well as opportunities to contrast the major contextual factors and policy triggers that influence health policy-making at the various levels.

Suggestions for Future Research

This project's findings demonstrated the potential influence of a post discharge protocol on future care site choices by non-urgent patients in the ED. Despite more than

half of the patients selecting the ED as their next potential source of non-urgent care, the project results supplied an abundance of strengths and limitations to be considered for future adaptations to patient's needs. Future study should examine the use of an edited protocol validated by experts in the field of emergency care, urgent care and retail clinic as well as primary care offices. Inquiry into primary care and reasons for lack of a steady provider would also be useful as it may lead to further changes throughout the healthcare field and open other subjects to scientific investigation. A larger sample size may be beneficial as well as collecting data at more than one facility for an extended period of time. An extended collection time frame may provide for a more robust sample and analysis of results. Examining more than one facility, whether from the same healthcare system or varying, could provide rich data on this topic as well as identify other barriers and possible solutions to the problem of ED misuse. Moreover, future studies should exam hospital EDs with and without already established RCUs to reduce bias and further exam the presenting population and their impact in the ED. A useful adaptation to this project could be surveying those patients who present to UCCs and RCs with non-urgent complaints and examining their reasons for choosing an appropriate site. A comparison between appropriate use and misuse of these care sites may prove to be useful in better identifying key factors that could lead patients to choose reciprocal sites for their complaints. Additionally, the survey content should be expanded to collect more information that would be useful in understanding the nature of the target population and the degree to which the results can be generalized to other EDs, UCCs, RCs, primary care settings and populations. Lastly, supplementary study into NP roles and the public's

perspective of NPs, more specifically DNPs, would serves as solid groundwork for further defense of their use in alternative care sites and on a system-wide level.

Summary

The use of the ED for non-urgent care continues to place a strain on our health care system. Presenting a single solution for a multidimensional topic oversimplifies a complex problem. With the expansion of advance nursing education and practice, the DNP-prepared NP holds infinite potential in delivering innovative and tangible solutions. Increasing patients' awareness of available alternative care sites, such as retail clinics and urgent care centers, over the use of the emergency department for a non-urgent complaint can help identify needed changes in our health care system in order to better serve the community. The project serves as a foundation for future scholarly inquiry and practice. Further development and analysis of this project and its findings can serve as a framework in establishing a system-wide change initiative to address the non-urgent use of the emergency department and the proper use of alternative care sites.

REFERENCES

Abbot, P. (2012, September). Crisis in emergency departments: The nurse practitioner role. *American Journal of Nurse Practitioners, 16*(9). Retrieved from http://webnponline.com/articles/article_details/crisis-in-emergency-departments-the-nurse-practitioner-role/

Adesara, R., Spencer, J., & Bost, J. (2011, November 30). Office-based patient education decreases non-emergent emergency department visits. *The Journal of Medical Practice Management, 27*(3), 131-135. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22283066

Afilalo, J., Marinovich, A., Afilalo, M., Colacone, A., Leger, R., Unger, B., & Giguare, C. (2004). Non-urgent emergency department patient characteristics and barriers to primary care. *Academic Emergency Medicine, 11*(12), 1302- 1310. Retrieved from http://onlinelibrary.wiley.com/doi10.1197.2004.08.032/pdf

Agency for Healthcare Research and Quality [AHRQ]. (2013, February) Emergency Severity Index (ESI): A triage tool for emergency department: DVDs and 2012 Edition of the Implementation Handbook. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.ahrq.gov/professionals/systems/hospital/esi/index.html

American Association of Colleges of Nursing [AACN]. (2006). *The essentials of doctoral education for advanced nursing practice. DNP essentials.* Washington, DC: Author.

American Academy of Nurse Practitioners [AANP]. (2006). Standards for nurse practitioner practice in retail-based clinics. Retrieved from

http://www.aanp.org/images/documents/publications/StdsforNPRetail-BasedClinics.pdf

American College of Emergency Physicians [ACEP]. (2011). *The ethics of health care reform – Issues in emergency medicine – An information paper*. Retrieved on from http://www.acep.org/Content.aspx?id=80871

Andersen, R. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(March), 1-10, Retrieved from http://www.jstor.org/discover/10.2307/2137284

Ashwood, J., Reid, R., Setodji, C., Weber, E., Gaynor, M., & Mehrotra, A. (2011). Trends in retail clinic use among the commercially insured. *American Journal of Managed Care, 17*(11), E443-448. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22200061

Caldwell, N., Srebotnjak, T., Wang, T., Hsia, R., & Zhang, H. (2013). "How much will I get charged for this?" Patient charges for top ten diagnoses in the emergency department. *PLoS ONE, 8*(2), E55491-E55491. Retrieved from http://www.plosone.org/article/info:doi/10.1371/journal.pone.0055491

Centers for Disease Control and Prevention (CDC), Gindi, R. M., Cohen, R. A., & Kirzinger, W. K. (2012). Emergency room use among adults aged 18-64: Early release of estimates from the National Health Interview Survey, January-June 2011. National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/nhis/releases.htm

Centers for Medicare and Medicaid Services (CMS). (2012). Emergency medical treatment & labor act (EMTALA). Retrieved from http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html

Consumer Reports. (2009, April). Urgent care: What you need to know. Retrieved from http://www.consumerreports.org/cro/2013/01/urgent-care-what-you-need-to-know/index.htm

Cunningham, P. (2006). What accounts for differences in the use of hospital emergency departments across U.S. communities?. *Health Affairs*, 324-336. doi: 10.1377/hlthaff.25.w324

Durand, A., Palazzolo, S., Tanti-Hardouin, N., Gerbeaux, P., Sambuc, R., & Gentile, S. (2012). Nonurgent patients in emergency departments: Rational or irresponsible consumers? Perceptions of professionals and patients. *BMC Research Notes, 5,* 2-9. doi: 10.1186/1756-0500-5-525

Elkum, N., Barrett, C., & Al-Omran, H. (2011). Canadian emergency department triage and acuity scale: Implementation in a tertiary care center in Saudi Arabia. *BMC Emergency Medicine, 11*, 3-3. doi:10.1186/1471-227X-11-3

Gentile, S., Vignally, P., Durand, A., Gainotti, S., Sambuc, R., & Gerbeaux, P. (2010). Non-urgent patients in the emergency department? A French formula to prevent misuse. *BMC Health Service Research , 10*(66), 1-6. doi: 10.1186/1472/6963-10-66

Fay, B. (2014). Emergency room vs. urgent care - Differences, costs & options. America's Debt Help Organization. Retrieved from http://www.debt.org/medical/emergency-room-urgent-care-costs/

Institute of Medicine (IOM). (2006, 2010). *The future of nursing: Leading change, advancing health*. Retrieved from http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

Lankford, K. (2010, April). 30 ways to cut health care costs. Kiplinger's Personal Finance. Retrieved from http://www.kiplinger.com/magazine/archives/30-ways-to-cut-health-care-costs.html

Masso, M., Bezzina, A., Siminski, P., Middleton, R., & Eagar, K. (2007). Why patients attend emergency departments for conditions potentially appropriate for primary care: Reasons given by patients and clinicians differ. *Emergency Medicine Australasia, 19*, 333-340. doi: 10.1111/j.1742-6723.2007.00968.x

McFadden, M. (2008, September 4). Local hospitals hurt by the abuse of the emergency room system. Retrieved from http://www.wndu.com/mmm/headlines.html

McWilliams, A., Tapp, H., Barker, J., & Dulin, M. (2011). Cost analysis of the use of emergency departments for primary care services in Charlotte, North Carolina. *American Journal of Managed Care, 4*(72), 265-71. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22128684

Mehrotra, A., Liu, H., Adams, J., Wang M.C.; Lave, J. R.; Thygeson, N. M…et. al. (2009, September 1). Comparing costs and quality of care at retail clinics with that of other medical settings for 3 common illnesses. *Annals of Internal Medicine, 151*(5), 321-328. Retrieved from https://annals.org/article.aspx?articleid=744702

Meisel , Z., & Pines, J. (2008). *The allure of one-stop-shop*. Slate. Retrieved from http://www.slate.com/articles/health_and_science/medical_examiner/2008/09/the_allure_of_the_onestop_shop.html

Merriam-Webster. (2015). Emergency room. Retrieved from http://www.merriam-webster.com/

National Priorities Partnership (NPP]. (2010, November). *Reducing emergency department overuse: a $38 billion opportunity. compact action brief: a road map for increasing value in health care*. Retrieved from http://www.nehi.net/publications/6-a-matter-of-urgency-reducing-emergency-department-overuse/view

National Institutes of Health (NIH). (2013, August 11). Choosing a primary care provider: MedlinePlus Medical Encyclopedia. National Institutes of Health: U.S. National Library of Medicine. Retrieved from http://www.nlm.nih.gov/medlineplus/ency/article/001939.htm

Twanmoh, J., & Cunningham, G. (2006). When overcrowding paralyzes an emergency department. *Managed Care Magazine Online.* Retrieved from http://www.managedcaremag.com/archives/0606/0606.peer_ER.html

Ragin, D., Hwang, U., Cydulka, R. K., Holson, D., Haley, L. L. Jr., Richards, C. F., … Richardson, D. B. (2005). Reasons for using the emergency department: Results of the EMPATH study. *Academic Emergency Medicine, 12,* 1158-1166. doi: 10.1197/ j.aem 2005.06.030

Rivers, S. (2003). Emergency department overcrowding in the United States: An emerging threat to patient safety and public health. *Emergency Medical Journal, 20,* 402-405.

Rosof, B. (2010). The busy emergency department. *American Journal of Medical Quality, 25,* 170-171. doi: 10.1177/1062860610364575.

Uscher-Pines, L., Pines, J., Kellermann, A., Gillen, K., & Mehrotra, A. (2013). Emergency department visits for nonurgent conditions: Systematic literature review. *The American Journal of Managed Care, 19*(1), 47-59

Weber, E., Showstack, J., Hunt, K., Colby, D., Grimes, B., Bacchetti, P., & Callaham, M. (2008). Are the uninsured responsible for the increase in emergency department visits in the united states? *Annals of Emergency Medicine, 2(52).* doi: 10.1016/j.annemergmed.2008.01.327

Weinick, R., Burns, R., & Mehrotra, A. (2010). How many emergency department visits could be managed at urgent care centers and retail clinics? *Health Affairs, 29*(9), 1630-1636. doi: doi:10.1377/hlthaff.2009.0748

APPENDIX A

BARRY UNIVERSITY IRB APPROVAL LETTER

Barry University
Division of Academic Affairs

Institutional Review Board
[redacted]

Research with Human Subjects
Protocol Review

Date:	February 12, 2015
Protocol Number:	141104
Title:	Discharge Alternative Non-Urgent Care Education (D.A.N.C.E.) Protocol Addressing Emergency Department Misuse
Meeting Date:	November 19, 2014
Researcher Name:	Ms. Samantha Leon
Address:	[redacted]
Faculty Sponsor:	Dr. Corvette Yacoob Nursing

Dear Ms. Leon:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the IRB have been made. Therefore, I have granted final approval for this study as exempt from further review.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on January 6, 2016. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with and IRB Application for Continuing Review (Progress Report) summarizing study results to date.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Barbara Cook at [redacted] or send an e-mail to [redacted]. Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

Linda Bacheller, Psy.D., J.D.
Chair, Institutional Review Board
[redacted]

Cc: Dr. Corvette Yacoob

APPENDIX B

STUDY SITE IRB APPROVAL LETTER

[redacted]

May 20, 2015

Samantha Leon, RN
[redacted]

RE: IRB 15-054: Discharge Alternative Non-Urgent Care Education (D.A.N.C.E) Protocol Addressing Emergency Department Misuse (PI initiated)

Dear Mrs. Leon:

I have reviewed your application for the study listed above. This study qualifies as Exempt in accordance with the protection of human subjects category: 45 CFR 46.101(b)(2) survery procedures. You may proceed and conduct your study as described in the IRB application.

Please notify the [redacted] Institutional Review Board (IRB) immediately if the study method is revised for which an exemption from IRB review would no longer be applicable. You must also notify the IRB if there are changes to study personnel.

Once you complete the study please send us a notification so that we may close our files.

You may contact the IRB Office at [redacted] if you have any questions.

Sincerely,

Maria J. Arnold, CIP
IRB Clinical Research Manager
[redacted]

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APPENDIX C

COVER LETTER – THE CONSENSUS PANEL

BARRY UNIVERSITY

COVER LETER

Dear Project Participant:

Your participation in an educational research project is requested. The title of the project is Discharge Alternative Non-Urgent Care Education (D.A.N.C.E) Protocol Addressing Emergency Department Misuse. The project is being conducted by Samantha C. Leon, BSN, RN, CEN, a student in the Doctorate of Nursing Practice program in the College of Nursing and Health Sciences at Barry University, and is seeking information that will be useful in the field of Nursing. The aims of the project are to increase awareness of and educate patients on emergency room use and alternative care sites. In accordance with these aims, the following procedures will be used: you will be assigned as a member on a panel of experts who will be presented with the D.A.N.C.E protocol and asked to determine the face-validity of the protocol and comment card.

We anticipate the number of participants for this panel to be 5 employees in the medical and/or nursing field with a Master's Degree or higher and/or at least 5 years of emergency room or urgent care experience. Your participation time will not exceed 4 hours.

Participation is strictly voluntary and should you decline to participate, there will be no adverse effects on your employment at this facility. There is no direct benefit or compensation for participating in the educational research project. Participants may gain awareness of patient's health seeking behaviors.

This is a minimal risk project. There may be some anxiety about establishing face-validity of a tool that will be distributed to patients for educational purposes. This risk may be minimized through voluntary involvement and face-to-face discussion on material allowing for open discussion that will not harm subjects.

Information you provide will be kept confidential, that is, no names or other identifiers will be collected on any of the instruments used. Any discussion or revisions made to the protocol will be maintained by the DNP student and the research team only.

If you have any questions or concerns regarding the educational project, you may contact me, Samantha C. Leon BSN, RN, CEN at [redacted], my supervisor, Corvette Yacoob, DNP, MSN, BC at [redacted], or the Institutional Review Board point of contact, Barbara Cook, at [redacted] or the [redacted] Institutional Review Board point of contact, Maria Arnold at [redacted]

Thank you for your participation.

Sincerely,

APPENDIX D

COVER LETTER – PATIENT PARTICIPANTS- ENGLISH AND SPANISH VERSION

BARRY UNIVERSITY

COVER LETER

Dear Project Participant:

You are being asked to participate in an educational research project. The title of this project is *Discharge Alternative Non-Urgent Care Education (D.A.N.C.E) Protocol Addressing Emergency Department Misuse.* The project is being conducted by Samantha C. Leon, BSN, RN, CEN, a student in the Doctorate of Nursing Practice program in the College of Nursing and Health Sciences at Barry University. This project is collecting information that will be useful in the field of Nursing. The goal of this project is to educate patients on the proper use of emergency rooms and alternative care sites. We expect the number of participants to be about 20.

If you decide to join in this educational research project, you will be asked to read the D.A.N.C.E protocol and complete a brief two question comment card. Your participation time should not take longer than 10 minutes.

Participation is strictly voluntary and if you decide not to participate, there will be no harmful effects on your healthcare or any change in services provided at this facility.

There is no direct benefit or compensation for being involved in this educational project but you may improve your awareness of alternate care sites and emergency rooms. There are minimal risks in this project that may include some anxiety about completing the protocol. This risk may be reduced by your involvement being completely voluntary and your identity being kept anonymous. Although it is highly unlikely to happen, if you experience anxiety related to being in this project, you are welcome leave the project and use the emergency department or a care site of your choice to treat this anxiety.

Information you provide will be kept confidential, that is, no names or other identifiers will be collected on any parts of the information collected. You will place your comment card in an assigned locked drop box when you have finished with the protocol. The cards will be kept by the DNP student and the research team only.

If you have any questions or concerns about the educational project, you can contact me, Samantha C. Leon BSN, RN, CEN at [redacted], my supervisor, Corvette Yacoob, DNP, MSN, BC at [redacted], or the Barry University Institutional Review Board point of contact, Barbara Cook, at [redacted] or the [redacted] Institutional Review Board point of contact, Maria Arnold at [redacted]

Thank you for your participation.

Sincerely,

BARRY UNIVERSITY

PORTADA

Estimado/a participante del proyecto:

Se le invita a participar en un proyecto educativo de investigación. El título de este proyecto es *Protocolo de Educación sobre Cuidados No Urgentes Alternativos al Alta (D.A.N.C.E.). Cómo abordar el mal uso del Departamento de Emergencias*. El proyecto está a cargo de Samantha C. Leon, BSN, RN, CEN, estudiante del programa de Doctorado sobre Prácticas de Enfermería en el Colegio de Enfermería y Ciencias Médicas de Barry University. Este proyecto recopila información que será útil en el campo de la Enfermería. El objetivo de este proyecto es educar a los pacientes en el correcto uso de las salas de emergencias y de las áreas de cuidado alternativas. Esperamos un número de participantes de aproximadamente 20 personas.

Si decide unirse a este proyecto educativo de investigación, se le pedirá que lea el protocolo D.A.N.C.E. y complete una breve tarjeta de comentarios de dos preguntas. Su tiempo de participación no será de más de 10 minutos.

La participación es estrictamente voluntaria y si decide no participar, no se producirá ninguna consecuencia negativa en su atención médica ni ningún cambio en los servicios prestados en estas instalaciones.

No habrá ningún beneficio directo o compensación relacionado con su participación en este proyecto educativo pero puede mejorar sus conocimientos sobre las áreas de cuidado alternativas y las salas de emergencias. Los riesgos de este proyecto son mínimos, los cuales pueden incluir cierta ansiedad al completar esta herramienta. Este riesgo se puede reducir ya que su participación es completamente voluntaria y su identidad se mantiene anónima. Aunque es muy poco probable que ocurra, si usted experimenta ansiedad relacionada con su participación en este proyecto, usted esta bienvenido(a) a abandonar el proyecto y utilizar el servicio del departamento de emergencias o cualquier otro sitio de atención médica de su elección para el tratamiento de esta ansiedad.

La información que proporcione tendrá un carácter confidencial, es decir, no se guardarán ni nombres ni ningún otro dato identificativo como parte de ninguna de las informaciones que se recopilen. Usted introducirá su tarjeta de comentarios en una caja cerrada asignada una vez haya acabado de completar la herramienta. Únicamente los estudiantes de DNP y el equipo de investigación guardarán las tarjetas.

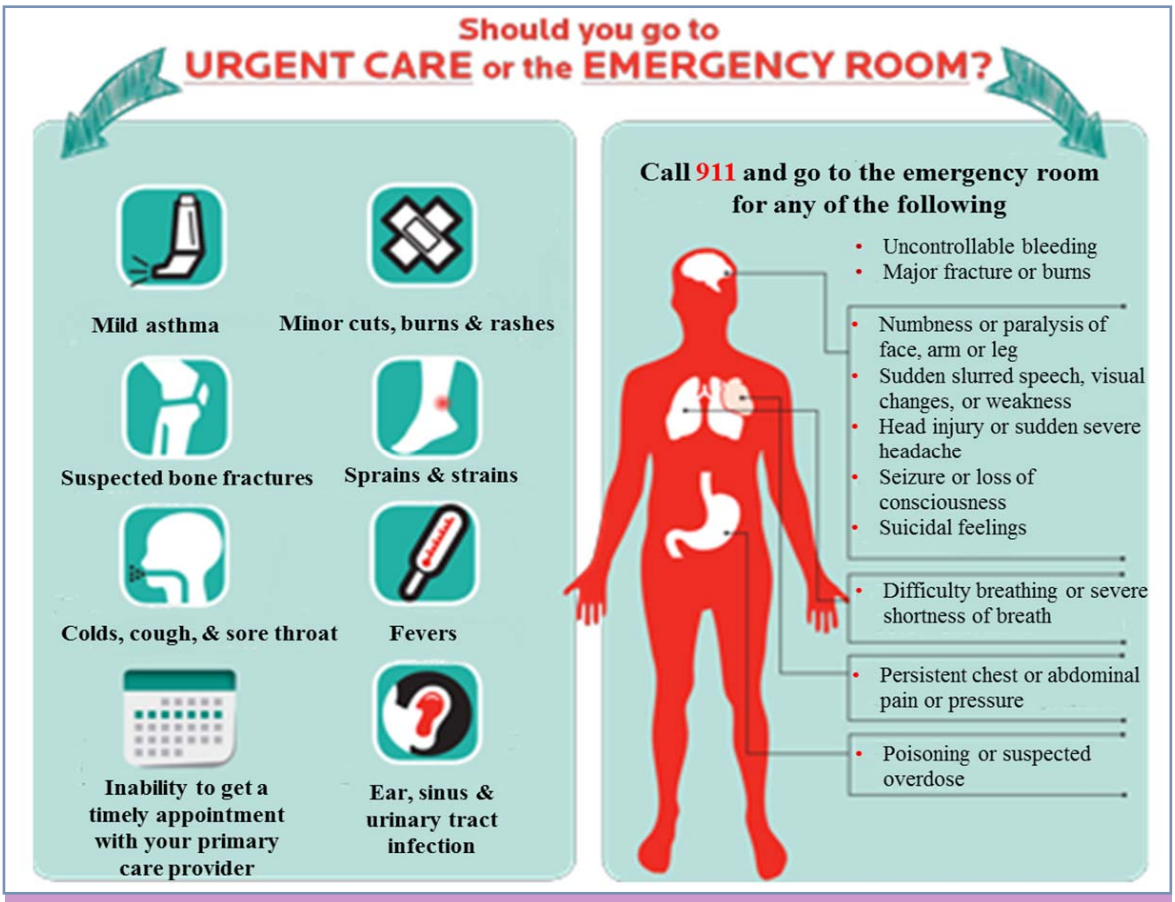
Si tiene alguna pregunta o duda sobre el proyecto educativo puede ponerse en contacto conmigo, Samantha C. Leon, BSN, RN, CEN, en el [redacted] mi supervisora, Corvette Yacoob, DNP, MSN, BC en el [redacted], o punto de contacto de la Junta de Revisión Institucional de Barry University, Barbara Cook, en el [redacted] o punto de contacto de la Junta de Revisión Institucional de [redacted], Maria Arnold en el [redacted]

Gracias por su participación.

Atentamente,

APPENDIX E

PROTOCOL AND SURVEY CARD – ENGLISH AND SPANISH VERSION



Retail Clinics

Located inside drugstores and supermarkets, these clinics treat a limited range of common illnesses and also provide some preventive services, such as vaccinations and prescription refills.

Emergency rooms tend to treat the patients with the most serious conditions first. So unless it's a true emergency, you will likely get quicker medical care at other care settings such as urgent care centers or retail clinics.

Use these locations when you need medical care quickly, but can't see your regular health care provider. They are usually staffed with doctors, nurses, physician assistants and nurse practitioners.

Get quality care quicker and pay much less than you would in the emergency department. Hours of operations may vary but they are usually open nights, weekends and holidays and do not require appointments.

Date: _____ Time:_____

D.A.N.C.E Protocol Survey Card

Where would you seek care next time you have the same or similar health care problem? Please check ONE care site from the list below:

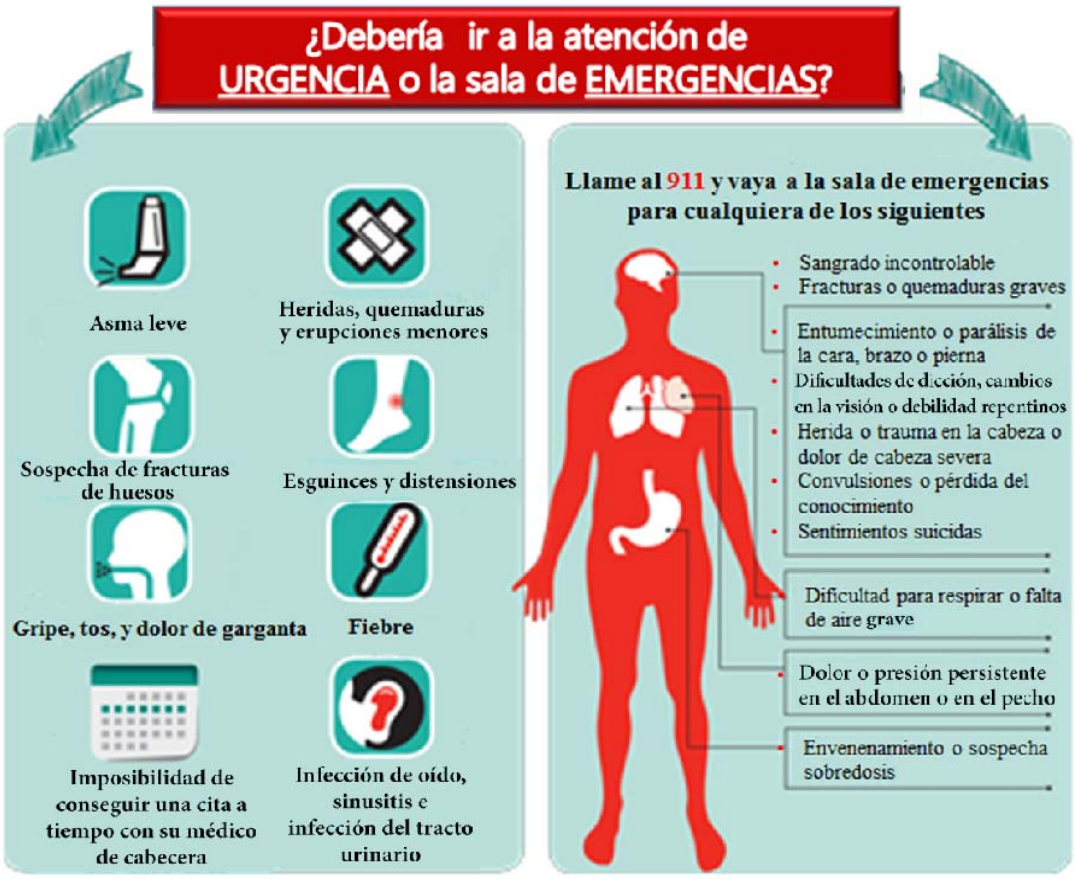
- The Emergency Room
- Urgent Care Center/ Retail Clinic
- Primary Care Provider

Did the D.A.N.C.E. Protocol help you make your choice above? Please circle ONE.

YES NO

When you have finished with your survey card, please fold and place the card in the locked drop box located at the front desk of the Emergency Room waiting room area.

Thank you.



Clínicas Minoristas

Ubicadas en las farmacias o en los supermercados, estas clínicas tratan una gama limitada de enfermedades comunes y también prestan algunos servicios preventivos, como vacunas o reposiciones de medicamentos con receta.

Las salas de emergencia tratan primero a los pacientes con las condiciones más graves. Así que a menos quese se trate de una verdadera emergencia, es probable que reciba una atención más rápida en otro sitio de atención médica, como en centros de atención de urgencia o en clínicas minoristas.

Utilice estos establecimientos, donde disponible, cuando necesite una atención médica rápidamente pero no pueda visitar a su proveedor de atención médica habitual. En ellos suele haber personal como médicos, enfermeros, asistentes médicos y enfermeros profesionales.

Consiga una atención de calidad más rápida y pague mucho menos de lo que haría en el departamento de emergencias. Los horarios de operación pueden variar, pero son generalmente abierto por la noche, los fines de semana y los días festivos, y no requieren citas previas.

Fecha: _____ Hora:_____

D.A.N.C.E Protocolo Tarjeta de Encuesta

¿Dónde buscara atención médica la próxima vez que tenga el mismo problema de salud? Por favor seleccione UNO de los siguiente opciones:

- La sala de emergencia
- Centro de atención de urgencia/ clínicas minoristas
- Médico de cabecera

¿El protocolo ha sido de ayuda en la selección de la respuesta anterior? Seleccione UNO.

SI NO

Cuando haya terminado con su tarjeta de encuesta, por favor doblar y colcar la tarjeta en el buzón situado en la recepción en la sala de espera de la sala de emergencia.

Gracias.

APPENDIX F

TRANSLATING SERVICE CERTIFICATE

ProTranslating

CERTIFICATE OF ACCURACY

The undersigned, Dr. Luis A. de la Vega, Chairman of ProTranslating, appearing on behalf of ProTranslating, hereby states, to the best of his knowledge and belief, that the foregoing is an accurate translation of the attached original document in the English language, consisting of three pages, and that this is the last of the attached.

(Samantha Leon - WALK)

Luis A. de la Vega, Ph. D.
Chairman
For ProTranslating

State of Florida
County of Miami-Dade

The foregoing certificate was acknowledged before me on this 27th day of May, 2015, by Dr. Luis A. de la Vega, Chairman of ProTranslating, a Florida corporation, on behalf of the corporation. He is personally known to me.

Notary Public

My commission expires:

ENKRII ZAMILAN
Notary Public - State of Florida
My Comm. Expires Jul 2, 2017
Commission # FF 032952

ProTranslating
Certified Translation

[redacted]

APPENDIX G

THE CONSENSUS PANEL RECRUITMENT FLYER

Do you work in this Emergency Room?

Your opinion is needed!

If you are currently working in this emergency room as a registered nurse or licensed medical provider, have a Master's degree or higher and/ or have at least 5 years of Emergency or Urgent Care experience, you are invited to participate in a voluntary research project titled:

"Discharge Alternative Non-Urgent Care Education (D.A.N.C.E) Protocol Addressing Emergency Department Misuse"

If you are willing to participate and have any questions about this research project, please contact:

Samantha C. Lowe, BSN, RN, CEN
(786)223-5922
Doctoral Student in the College of Nursing and Health Sciences
at Barry University
or
Dr. Corvette Yacoob, DNP, MSN, BC, Committee Chair
(305) 899-3100
or
Barbara Cook, Institutional Review Board point of contact
(305) 899-3020

APPENDIX H

PATIENT PARTICIPANT RECRUITMENT FLYER- ENGLISH AND SPAISH VERSION

You are invited to participate in a Doctorate of Nursing Practice Project

"Discharge Alternative Non-Urgent Care Education (D.A.N.C.E) Protocol

Addressing Emergency Department Misuse"

You must be a patient discharged from the Emergency Department, 18-64 years of age, and English and/or Spanish speaking to participate.

If you are willing to participate and have any questions about this research project, please contact:

Samantha C. Leon, BSN, RN, CEN
(786)223-5922
Doctoral Student in the College of Nursing and Health Sciences
at Barry University

or

Dr. Corvette Tacoob, DNP, MSN, RC, Committee Chair
(305) 899-3100

or

Barbara Cook, Institutional Review Board point of contact
(305) 899-3020

Se le invita a participar en un Proyecto de Doctorado sobre Prácticas de Enfermería

Protocolo "Educación sobre Cuidados No Urgentes Alternativos al Alta (D.A.N.C.E.)

Cómo abordar el mal uso del Departamento de Emergencias"

Debe ser un paciente dado de alta del Departamento de Emergencias, de 18-64 años, fluente en Inglés y/o Español para participar.

Si desea participar y tiene cualquier pregunta en relación con este proyecto de investigación, comuníquese con:

Samantha C. Leon, BSN, RN, CEN
(786) 223-9922
Estudiante de doctorado en el Colegio de Enfermería y Ciencias Médicas
de Barry University

o

Dr. Corvette Yacoob, DNP, MSN, RC, Presidente de Comité
(305) 899-3100

o

Barbara Cook, punto de contacto de la Junta de Revisión Institucional
(305) 899-3020

VITA

Samantha C. Leon, BSN, RN, CEN

EDUCATION

Barry University, Miami Shores, FL
Doctorate of Nursing Practice in Family Practice **2015**
Post Baccalaureate to Doctorate Program

Florida International University, Miami, FL
Bachelors in Science in Nursing **2011**
Honors: Dean's List

Miami Dade College, Miami, FL
Associate in Science in Nursing **2009**

Miami Dade College, Miami, FL **2007**
Associate in Arts
Honors: Associate degree awarded with Honors

Hialeah Senior High School, Hialeah, FL **2005**
High School Diploma
Honors: Superintendent's Diploma of Distinction

LICENSES/ CERTIFICATIONS

Registered Nurse License# 9295674
(State of Florida Department of Health)
Certified Emergency Nurse (CEN) # 981106324
(Board of Certification for Emergency Nursing)
Trauma Nursing Core Course (TNCC) Verification
(Emergency Nurses Association)
Air Medical Crew Course
(Department of Transportation)

EMPLOYMENT HISTORY

Trinity Air Ambulance International, LLC
Emergency Medical Air Transport- Flight Nurse- on call **2014- Present**

West Kendall Baptist Hospital- Miami, FL
Emergency Department- Clinical Staff Nurse/ Charge Nurse Relief- Full-time/ Per Diem **2011- Present**

Jackson North Medical Center, North Miami Beach, FL **2009-2011**
Emergency Department- Clinical Staff Nurse- Full-time

PUBLICATIONS

Lambda Chi Chapter Sigma Theta Tau International "Translating Evidence Into Practice" Poster Presenter **2014**

West Kendall Baptist Hospital Quality Improvement Research Poster Presenter **2012**