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LaWanda Baskin

The University of Southern Mississippi, lawanda.baskin@usm.edu

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Patient Advocacy: A Tool for Resolving Ethical Issues for Patients That Use the Emergency Department for Chronic Care Management

LaWanda Baskin, PhD

University of Southern Mississippi

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ABSTRACT

The current state of scientific knowledge on using the emergency department (ED) for chronic care management indicates that using the ED for chronic care management creates health disparities and burdens healthcare systems. Ethical concerns also arise because patients use the ED for chronic care management. This article discusses health literacy, self-care behaviors, and social support and the presence of patient suffering, nonmaleficence, and beneficence in patients who seek care for chronic care management in the ED. Patient advocacy as a tool to lessen these ethical issues is further discussed. Eighty-six participants were used in a cross-sectional correlational predictive study. Findings indicated that predictive relationships exist between health literacy, social support, and self-care behaviors and using the ED for chronic care management in the sample population. Key implications from this research are the need for patient advocacy to improve health literacy, self-care behaviors, and social support among patients with chronic conditions.

Introduction

Patient advocacy in nursing takes on many different meanings. Jansson et al., (2014) refers to patient advocacy as "one strategy for assisting patients with important problems that might not otherwise be addressed" (p. 163). Butts and Rich (2020) defined patient advocacy as "pleading in favor of or supporting a case, person, group, or cause" (p. 78). Nurses work closely with patients and are situated in such a way that they can inquire about the many needs of the patients (Butts & Rich, 2020). Nurses strive to maintain patient anonymity, to preserve patient dignity during treatment, and to speak for those who cannot speak for themselves. Patients who are unconscious in intensive care units (ICUs) or operating rooms (ORs) depend on the advocacy of nurses. These settings are a few places where nurses ensure that the patient is safe from harm related to positioning or equipment use. The emergency department (ED) is another area that nurses act as patient advocates. In this setting, nurses advocate alongside the patient. As advocates, nurses provide direct care and education to patients in the ED. Nurses also work to address patient concerns about care being provided. Oftentimes, patients that seek care in the ED do so because they do not have a primary care provider. In this case, nurses work to identify primary care providers and other support services for the patient.

According to the National Hospital Ambulatory Medical Care Survey, a total of 139 million emergency department (ED) visits occurred in the United States from December 26, 2016 to December 24, 2017 (Rui & Kang, 2017). Of those visits, 40 million were injury-related visits, but only 14.5 million visits resulted in

hospital admissions (Rui Kang, 2017). Using the ED for primary care has created an increase in patient loads and a heavy economic burden on the healthcare system. According to the Agency for Healthcare Research and Quality (2017), more than 650 million dollars were spent on ED services in 2014. Considering these staggering numbers, healthcare providers must acknowledge their ethical responsibilities to this population of patients. Many healthcare providers and administrators are concerned with the cost associated with ED visits, crowded conditions related to these visits, and the idea that chronic care management should occur at the office of the primary care provider. Advocacy plays an important role in improving self-care and increasing the use of social support services. As an advocate, nurses provide explanations and educational information to patients. The explanations and educational information help to improve patient understanding of health conditions or ongoing treatment plans. Nurses also can be found offering immediate support to patients and help to identify support services for those that need assistance outside of the ED.

Baskin (2017) explored the relationships of health literacy, self-care behaviors, and social support as predictive factors on the use of the emergency department for chronic care management in patients with hypertension (HTN) and/or type 2 diabetes mellitus (T2DM). The populations of patients who use the ED for chronic care management have been cited as causing an ever-growing, long-standing global issue (Hussey, et al., 2014; Gindi, et al., 2016). Patients with and without insurance, the elderly, and those caring for

pediatric patients, along with chronically-ill patients have been cited throughout literature as seeing the ED as a convenient place to receive care (Grant, et al., 2010; Usher-Pines, et al., 2013). Many scholars agree that patients perceive their actions as the correct actions when seeking care in the ED. The cost of health care, overcrowding in emergency departments, and underuse of primary care providers is on the rise. With these growing issues comes the need for the use of patient advocacy to ensure quality care and ethical treatment of all patients.

Purpose

This study utilized a cross-sectional predictive design to determine to what extent do identified factors (i.e., health literacy, social support, and self-care behaviors) predict ED usage decisions. The literature was not specific in these relationships, and a gap was identified in the literature regarding the practice of using the ED for chronic care management in the southwest United States. Specifically, this study sought to explore the extent to which health literacy, social support, and self-care behaviors predict the use of the ED for chronic care management in patients with HTN and/or T2DM ages 30-64 years. The purpose of this study was to examine the relationship and predictive effects of health literacy, self-care behaviors, and social support on the use of the ED for chronic care management in male and female patients between the ages of 30-64 years diagnosed with hypertension (HTN) and/or type II diabetes mellitus (T2DM). This article will discuss health literacy, self-care behaviors, and social support and the resulting precipitation of patient suffering, nonmaleficence, and beneficence in patients who seek care for chronic care management in the ED. The article will further discuss how patient advocacy works to lessen these ethical issues.

Methodology

A cross-sectional correlational predictive study design was used. The target population for this study was adult residents of Mississippi and Louisiana with HTN and/or T2DM. Participants were excluded if: they had mental illness, did not speak English, were over the age of 64, under the age of 30, were institutionalized, and pregnant. A convenience sample (N=86) was recruited from a primary care clinic, a small rural hospital, a church congregation, and the members of a local chapter of a social organization; all in the southeastern United States, particularly Mississippi. All ethical considerations were considered during recruitment, data collection, and analysis. Institutional Review Board approval was obtained, and permission to collect data at the selected sites was received. Informed consent was obtained. Participants were also informed of their right to withdraw from the study at any time.

This study measured three variables and explored their predictive effect on the use of the ED for chronic care management in patients with HTN and/or T2DM ages 30-64 years. A demographic questionnaire developed by the researcher was used to gather socioeconomic status, educational level, insurance status, age, gender, race, ethnicity, and information regarding use of the ED for chronic care management.

All participants were administered the Short Test of Functional Health Literacy in Adults (S-TOFHLA), the Sidani Doran Therapeutic Self-Care Measure (SDTSCM), and the Medical Outcomes Study social support survey (MOSSSS).

Health literacy was measured using the S-TOFHLA. This tool is the short form of the Test of Functional Health Literacy in Adults (TOFHLA) and was retrieved from Peppercorn Books. The S-TOFHLA has four numeracy items and two prose passages. The first of the two prose passages has a readability of 4.3 and the second prose passage has a readability of 10.4. The TOFHLA is found to have good reliability and validity (Baker, Williams, Parker, Gazmararian, & Nurss, 1999). The Cronbach's alpha is 0.68 for the numeracy items and 0.97 for the items related to the prose passages. The S-TOFHLA can be administered to the participant in approximately 7 minutes.

The second variable, self-care behaviors was measured using the Sidani Doran Therapeutic Self-Care Measure (SDTSCM) that was retrieved from the public domain at Flintbox.com. Psychometric analysis by Sidani and Doran (2014) found the measure to be reliable and valid. All items were found to be internally consistent. The item-to-total correlation coefficients ranged from .47 to .74, and Cronbach's alpha was .89. Construct validity of this measure was also established. The correlation coefficient was .19 suggesting that there was statistically non-significance between the group who had reportedly been given self-care instructions and the group who had not been given self-care instructions. The 13-item SDTSCM was administered by the researcher in an interview format.

The final variable, social support was measured by the Medical Outcomes Study social support survey (MOSSSS). This survey was also retrieved from the public domain at rand.org. Reliability and validity of the MOS social support survey was established and reported by Sherbourne and Stewart (1991). Cronbach's alpha of the social support subscales ranged from 0.91 to 0.97, establishing internal-consistency reliability. All concepts of the measure were significantly correlated at $p < 0.01$. Developers of the MOS social support survey designed the measure to be brief, simple, and easy to understand and therefore able to be administered to chronically ill patients (Sherbourne & Stewart, 1991).

Results

The target sample size of 86 participants was achieved. Participants were recruited from four different facilities (a clinic, a church, a hospital, and a social organization). The quality of data collection was high and there were no missing values or outliers. Approximately 26% (n=22) of the participants were recruited from the clinic, 42% (n=36) were recruited from the church, 20% (n=18) were recruited from the hospital, and 12% (n=10) were recruited from the social organization. Among the total sample, 63% (n=54) were female and 37% (n=32) were male. Participants ranged in age from 30 to 64 years with a mean age of 50.22 years (SD=11.53). Most of the sample self-identified as African-American (72%), non-Hispanic (91%) and reported a household income of less than \$30,000 (65%). Thirty-six percent of the sample (n=31) reported 'Yes' to using the ED for the management of HTN and DM,

while 64% (n=55) reported 'No' to using the ED for the management of HTN and DM. Sixty-three percent (n=54) were diagnosed with HTN and 70% (n=60) were diagnosed with DM. The total sample was well educated with 48% (n=57) reported having completed at least 1-3 years of college.

Among the total sample, health literacy scores from the S-TOFHLA ranged from 16 to 36 with a mean of 33.08 (SD=4.59). Self-care scores received from the SDTSCM ranged from 2.00 to 5.00 with a mean of 4.27 (SD=.81), and overall social support scores from the MOSSSS ranged from 2.00 to 5.00 with a mean of 3.85 (SD=1.07). A complete summary of scores is provided in Table 1. The MOSSSS performed well with this study sample, $\alpha = .97$. Descriptive statistics, bivariate analyses, and logistic regression analysis were conducted, using International Business Machines Statistical Package for the Social Sciences version 23.0.

Bivariate analyses were conducted to determine the relationship between health

literacy, self-care behaviors, social support, and using the ED for chronic care management. Health literacy, self-care behaviors, and social support were significantly correlated with use of the ED, $p < .05$. The bivariate analyses also confirmed that all three independent variables can be included in the regression model. Logistic regression was performed to assess the predictive impact of health literacy, self-care, and overall social support on use of the ED for chronic care management. Preliminary analyses were conducted to ensure no violation of applicable assumptions. The model contained three independent/predictive variables (health literacy, self-care, and overall social support). The full model containing all predictors was statistically significant, $\chi^2 (3, N = 86) = 54.58, p < .05$, indicating that the model was able to distinguish between participants who reported use of the ED ('Yes') and participants who did not use the ED ('No'). The model as a whole explained between 47% (Cox and Snell R square) and 64.4% (Nagelkerke R squared) of the variance in ED use and correctly classified 88.4% of the cases. The correct classifications rate for ED use was noted as 77.4 and 94.5 for non-ED use. Only one of the independent variables made a unique statistically significant contribution to the model (overall social support). Overall social support was the strongest predictor of a person not using the ED, recording an odds ratio of 11.27. An odds ratio of 11.27 indicates that participants who had higher overall social support were 11.27 times more likely to not use the ED than those who had lower overall social support, controlling for all other factors in the model.

Interpretation of findings

The objective of the research study was to identify and examine the relationship and predictive effects of health literacy, self-care behaviors, and social support on the use of the ED for chronic care management in male and female patients between the ages 30-64 years diagnosed with HTN and/or T2DM. This study found that health literacy, self-care, and social support were related to use of the ED. Dorothea Orem's Self-Care Framework was utilized to help guide this study. Orem (1995) defined self-care as "deliberate action that enables the individual to survive in a variety of states

of well-being or health to move from one state to another" (p. 120). Self-care is behavior. The theory of self-care requisites is a component of Orem's Self-care Deficit Nursing Theory (SCDNT). Orem's SCDNT encompasses actions needed to be performed by or for the individual "to maintain human structural and functional integrity" (p. 191). The behavior of self-care in this study was measured and findings suggest that self-care was significantly correlated with the use of the ED for chronic care management in the sample population. Findings of the study reflect that health literacy, self-care, and social support are all significantly correlated with the use of the ED. Similar to this study's findings, Walker, Schatz, Johnson, Silverstein, and Rohrs (2015) found a significant correlation of social support with their study dependent variable. These authors suggested that a lack of social support was a source for health disparities in the health outcomes of youths with type I diabetes mellitus.

Findings of this study supported that when controlling for other factors there was one predictive factor that made a stronger significant contribution. Overall social support was found to be the strongest predictor of a person not using the ED for chronic care management. Findings indicated that those in the sample population who had a high overall social support index were more likely not to use the ED for chronic care management.

Recruitment Site	n	Minimum	Maximum	Mean	SD
Clinic					
Health Literacy	22	22	36	33.14	3.27
Self-Care	22	2	5	4.27	1.02
Overall Social Support	22	2	5	3.81	1.02
Church					
Health Literacy	36	16	36	33.86	4.54
Self-Care	36	2.67	5	4.31	.58
Overall Social Support	36	2	5	4.11	.99
Hospital					
Health Literacy	18	20	36	30.50	6.14
Self-Care	18	2	5	3.98	1.02
Overall Social Support	18	2	5	3.27	1.13
Social Org					
Health Literacy	10	30	36	34.80	2.09
Self-Care	10	4	5	4.68	.41
Overall Social Support	10	2.21	5	4.02	.99

Discussion

The results of this study provide the field of nursing with building blocks to provide resolutions for ethical issues and conflicts that arise in the ED. The fact that many patients utilize the ED for chronic care management is a long-standing issue. Recognizing that there are ethical issues that arise and identifying how to resolve them lies with the healthcare provider. Acknowledging that the patients are experiencing a perceived level of suffering might prove to be helpful as well. The patients and caregivers are experiencing a level of patient suffering that causes them to reach out to what they believe to be an appropriate resource for care. Suffering of a patient with a chronic illness can be subjectively and objectively identified, according to Butts and Rich (2020). Patient suffering is an ethical concern that must be considered. In order to eliminate their suffering, patients visit EDs because of the convenience of the 24-hour care provided (Baskin et al., 2015). As patients seek care to help alleviate their suffering healthcare providers should provide care and support. Patients expect that their needs for control of pain or other symptoms will be attended to regardless of the health system's perception of urgency or emergency.

Healthcare providers should be certain that ethical treatment is provided to patients regardless of their reason for visiting the ED. Although a decrease in non-urgent visits could assist with decreasing the patient load in currently overcrowded EDs. The stigma associated with why patients are seeking care for chronic care management should not overshadow ethical treatment. Healthcare providers have a duty to do no harm. Nonmaleficence necessitates that what is cause harm to patients. Healthcare providers have a duty to do no harm to those patients who seek care in the ED whether the providers or facility feel that the visit is appropriate or not. As found in this study, patients with low health literacy may not understand that the ED level of care is inappropriate for their treatment. Patients also may treatment is appropriate for them. Advocates in the ED should provide quality care and receive feedback from patients to make certain that all patients are receiving adequate care without harm.

This study also revealed that patients seeking care in the ED for chronic care management have decreased self-care behavior levels. Beneficence, our duty to do in the best interest of the patient without regard to how they may treat them self (self-care behaviors), requires that we care for these patient and provide treatment and resources without regard to how they may care for themselves at home. Overall, lack of social support weighed in as the most likely predictor for patients to seek care in the ED for chronic healthcare providers not care management. By providing support, nurses can make a great impact. As patient advocates, nurses can provide support and encouragement to patients. Patient advocacy can also be utilized to help patients in this setting identify support systems that can assist with all of the ethical issues that arise, as well as help to improve their overall health outcomes, increase health equity, and decrease health disparities.

Nurses, advanced practice nurses, physicians, and other members of the healthcare team should work together as patient advocates to evaluate and identify the social support needs of their community. Working together they can develop and implement more social support programs. Findings of this study suggest that increased social support would decrease the use of the ED for chronic care management in the sample population. The development of social support systems may provide patients that have chronic conditions with the social support interactions that they are lacking. If patients have the social support interactions that they require, there could ultimately be a decrease in the number of patients using the ED for chronic care management, thus decreasing the economic burden caused by overcrowding in the ED.

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Corresponding Author

LaWanda Baskin, PhD
University of Southern Mississippi
LaWanda.Baskin@usm.edu