Factors Associated With Nonurgent Use of Pediatric Emergency Care Among Latino Families

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Objective: This study investigates Latino parents' decision to seek pediatric emergency care for nonurgent health conditions.

Methods: Three focus groups were conducted with Spanish-speaking parents. Eligible families had a pediatric primary care provider, and their child received emergency treatment for a nonurgent health condition in the previous year. Transcripts were transcribed, translated, and thematically coded.

Results: Parents shared a heightened concern about symptoms such as fever or diminished energy. Many related experiences where delay resulted in serious illness or death. Other factors included low utilization of telephone triage and long clinic wait times. Nearly every family had managed the child's illness at home prior to seeking care, employing medical and natural remedies.

Conclusions: The study findings suggest that strengthening the connection with a child's medical home, eliminating barriers to receiving primary care in urgent situations and educating parents about management of common illnesses may improve care for Latino children.

Keywords: emergency care ■ health service utilization ■ Latinos ■ children's health

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As health care systems strive to deliver high-quality care, there is a growing focus on the medical home to improve access to care, increase care satisfaction, and improve health.[1-6] Patients receiving care through their medical home have more preventive screenings, higher quality of care, and fewer racial/ethnic disparities.[7] For nonurgent health conditions, an emergency department (ED) visit represents a potential lost opportunity for relationship building with the medical home.[8] Nonurgent visits to the ED increase the cost of care and ED wait times, with detrimental effects on the quality of care for others requiring emergency treatment.[9-14]

Access to medical care among Latinos has been limited by social, economic, and cultural barriers.[15] Almost half of first-generation Mexican American children have not seen a doctor in the past year, compared to one-quarter in other groups.[16] These children are less likely than non-Latino whites to have a usual source of care. Latinos are more likely to take their child to the ED for fever (55% vs 21% whites)[17] and asthma,[18,19] but have fewer ED visits for injury[20] and less access to preventive care.[9,18,21,22] A recent study showed that Latino ethnicity was associated with increased ED use among pediatric Medicaid beneficiaries, though the study excluded Spanish-language–only patients.[23]

The purpose of this study was to understand factors that influence Latino parents' use of the ED for nonurgent health conditions, including cultural attitudes and beliefs about seeking care, for children with established primary care. We wished to understand the reasons Latino families bring their children to the ED and how they seek health information prior to an ED encounter. We wanted to identify the barriers and facilitators families encounter when seeking care at their child's clinic. Finally, we wished to investigate key factors influencing the decision to seek care—specifically, the choice between seeking care at the clinic compared to the ED.

METHODS

Study Design

We conducted focus groups to explore behavioral factors associated with nonemergent ED use by Latino

children and their families.

The study was conducted at Seattle Children's Hospital in Seattle, Washington, an urban, 250-bed pediatric medical center. The hospital treats 190 000 children annually, and 15% of families self-identify as having limited English proficiency. The ED serves approximately 30 000 patient encounters annually.

This study was approved by the Seattle Children's Hospital institutional review board.

We reviewed retrospective ED records to identify pediatric patients who received ED care between September 2008 and September 2009. Similar to other studies examining nonurgent care,[24-28] ED encounters were excluded if any laboratory test, radiography, or electrocardiogram was performed during the visit or if the patient was admitted to the hospital. We only included children with a previously identified primary care provider. Spanish-speaking families were included if the parent was identified as having limited English proficiency. We further restricted participation to those living in 6 zip codes surrounding the focus group location to reduce the transportation burden for participants. From a list of 490 eligible participants, parents were called using a random number generator to determine calling order until all participant slots were filled. Parents were excluded if they had been living in the United States for more than 10 years.

Methods

A bilingual staff member of Seattle Children's Hospital, certified as an interpreter, contacted participants by phone and administered a brief screening questionnaire to ensure eligibility criteria were met. Verbal consent was obtained from 1 eligible caregiver through a phone-based interview. Parents received a reminder call within 2 days of the focus group. Each participant was given an information sheet, which was reviewed prior to the meeting, and received a $20 grocery gift card. Three 1.5-hour focus groups were held at a community site, each containing 5 to 9 participants led by a bilingual, bicultural facilitator (moderator prompts described in Box 2). Discussion audiotapes were professionally transcribed, checked for accuracy by one of the bilingual authors, and translated into English for analysis.

Data Analysis

Transcripts were analyzed using grounded theory, in which new theory describing behavioral factors is generated and existing theory is refined by comparison with incoming information.[29] Relevant themes and subthemes in the transcript text of each focus group session were highlighted and margin coded. Three investigators independently identified the themes central to the discussion, then identified and categorized individual comments. The transcripts were initially coded into distinct units of meaning, then into categories based on similarities. A taxonomy of themes and subthemes was created. Coding differences were resolved by consensus.

RESULTS

Forty-three eligible, randomly chosen Spanish-speaking parents were invited to participate (Figure). Of these, 20 participated in focus groups (47%). The Table describes the characteristics of invited participants. Most parents were of Mexican heritage (84%). The majority of participants were female immigrants who had been living in the United States for 6 to 10 years. Fourteen percent were high school graduates. Qualitative results and identified themes are summarized in Box 1 and discussed below.

Home Care for Child Prior to Seeking Medical Attention

All parents described efforts to treat the child's symptoms at home prior to seeking care. Often, the family sought care after several days of caring for the child, giving antipyretic medicines and home remedies. Experienced parents seemed more comfortable managing symptoms at home: "I gave her Tylenol, but no, it didn't work. So…we gave her time to sleep, and after she woke up, we observed her reactions. At the end, we decided to take her to the hospital." Another parent stated, "…a neighbor told me to give [my son] mint tea…instead of curing the indisposition it made it worse. I told the doctor and he said, 'And is your neighbor a doctor or what?'"

Natural medicine use was widespread and discussed extensively in each group. Examples included drinking teas, advice to "drink something bitter," applying fresh herbs on the child's forehead and stomach to "break the fever," massaging the child with Vicks VapoRub (Procter & Gamble, Cincinnati, Ohio) ointment or alcohol, placing perfumed cotton in the ear to cure earache, and giving vitamins and calcium when girls start menstruation. Several participants commented on the intersection between traditional beliefs and a medical model of care, noting that most families tried both approaches.

Parents sought information to supplement their experience and knowledge. A common approach was to seek advice from family and friends still living in their country of origin. A number of different respondents described using pharmaceuticals mailed from Mexico or transporting antibiotics in luggage during trips.

Few parents sought guidance from Spanish language nursing help lines during and after clinic hours. For those who knew this service existed, it was a valued source of information. Most parents were unaware of this resource. Families who called nursing help lines were more comfortable talking with bilingual providers. Parents also sought information from books and educational materials given by their child's doctor in a kit or list. Several had attended an educational program through Head Start that gave families a Spanish-language health reference book and demonstrated its use.

[When I called the nurse line]...they asked step by step, depending on how the child is, what he has, all the symptoms. They calmed me down because I was very nervous, I was even shaking; I couldn't even talk.

Another parent said, "[When my child is sick] I ask family members in Mexico City. They send messages from their mothers."

Parent Decision to Seek Medical Care

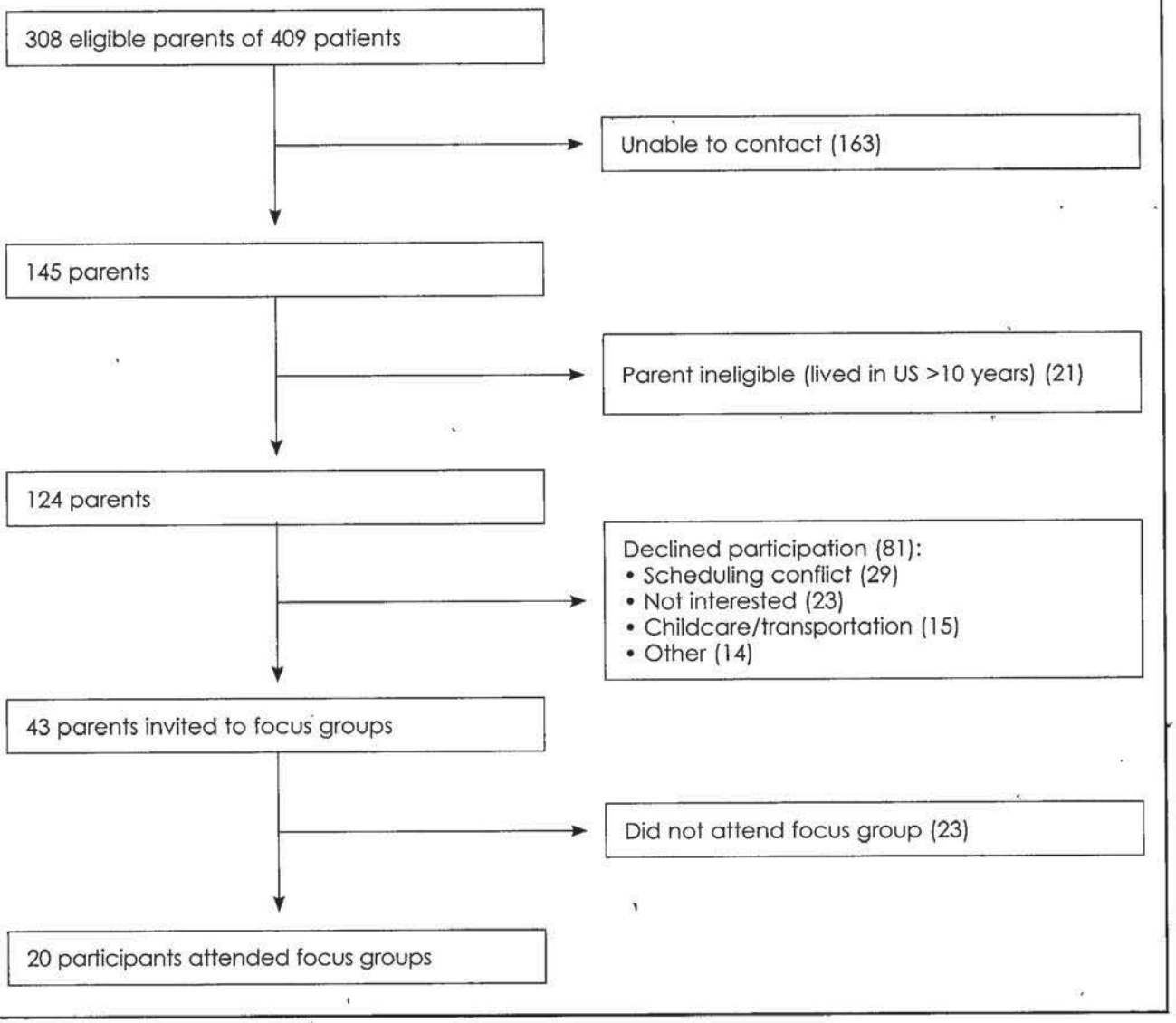
Caregivers described many factors influencing the decision to bring the child for care. This decision was influenced by the child's condition, parent experiences, and cultural expectations. Parents were deeply concerned about the child's fever, often giving acetaminophen but then seeking medical care when the fever returned. Another common cause for seeking care was the perception that the child had diminished energy or that symptoms were not improving:

[When his fever comes back after giving Tylenol, then the medicine] is no longer working...I have to take him to a doctor...I don't think it's normal that [the fever] goes away and comes back.

Many parents shared personal stories of a heartbreaking nature in their country of origin, where a delay in care or inattention to the patient's condition resulted in a serious outcome or even death. It was clear that these anxieties influenced their care decisions. One mother recounted a story about a neighbor whose son developed a fever, then a seizure, and subsequently was profoundly developmentally delayed. She observed, "Look how long she's been struggling with her son; they have to carry him everywhere. And why? Because of a fever..." Another parent noted that when a child has a fever, "We have to take the child [to the ED]...because you never know what could happen, even a minute too long could change things..."

Many parents commented on differences between medical care in their country of origin, and

Figure. Participant Eligibility and Recruitment



their experiences in the United States. Parents were accustomed to receiving "definitive" treatment on the spot, delivered by the doctor. As one parent described,

[In Mexico] you take the child to the doctor, and right there and then, the doctor gives you antibiotics and everything.... Injections and the child quickly heals. You come here, and you only get Tylenol or Motrin. That's it. 'Take him home, wait 2 or 3 days.' Only if he is still sick [will] they give you an antibiotic."

Positive experiences with children who recovered quickly after previous illnesses made parents feel more comfortable with caring for their children at home. Parents became worried in response to duration of symptoms beyond the expected time or when new or unexplained symptoms developed. Parents were also reluctant to continue care at home when the child was not improving or worsening.

Decision to Seek Emergency Care

All patients in our study had an assigned primary care provider and so had a theoretical choice in where to seek care for minor illnesses. We explored the reasons why families chose the ED over their assigned physician. Accidents or illnesses requiring care after clinic hours were brought to the ED. Parents rarely called the clinic nurse advice line prior to seeking care. Opinions about seeking care ranged from an immediate visit to the ED to waiting until the morning to be seen in clinic. Influential factors in this decision were similar to those influencing their decision to seek care with any physician, with some parental discretion on when they were too sick for the clinic.

Avoiding double wait times was an important determinant of seeking care in the ED. As patients routinely had long waits to be seen in the clinic, the idea that one might have to "wait twice"—once in clinic and then again at the hospital—made parents more likely to seek ED care directly. This was most common when parents felt they would eventually be referred to the ED or if they worried the child's clinical status might worsen during the wait. Some parents found it particularly hard to obtain same-day clinic appointments for an acute illness. One mother stated,

Without [a prior clinic] appointment, I'll have to wait 2, 3 hours [at the clinic]...So I prefer to go to the emergency room and get something that might help him. Then perhaps I can return home before midnight and avoid getting an IV.

Long wait times with a clinic appointment were equally frustrating.

The ED was preferred to the clinic for acute care and when an adequate diagnosis was not given in clinic: "The clinic just works for checkups, to see if they're growing healthy or not. But for emergencies or other illnesses [the hospital ED] is the right place." One parent said, "In the clinic, they just check the child and 'pum' [the visit] is over, without knowing what is really wrong." Another said, "...if I don't agree [with the diagnosis], I go to the emergency room."

There were also factors which discouraged parents from seeking ED care. Long wait times were repeatedly mentioned by all participants. Others had had a negative experience after seeking care, such as having the ED staff contact Child Protective Services.

...I've been there waiting in the emergency room for a long, long, long time. Even though she is sick, my daughter says, "Let's go, let's go, I want to go home," and she starts crying.

Table. Demographic Characteristics of Invited Participants (n = 43)

Characteristics	%
Caregiver age, y	
18-25	19
26-35	65
36-45	14
46-55	2
Caregiver sex	
Male	21
Female	79
Country of origin	
Mexico	84
Central America (Guatemala, El Salvador, Honduras, Nicaragua)	16
Time in United States, y	
<5	16
6-10	84
Caregiver school attainment	
Grade 1-6	28
Grade 7-9	33
Grade 10-11	26
High school degree	9
Some college	5

Perceptions of Emergency Care

Participants were pleased with the quality of ED care. They reported a thorough exam, availability of specialists and ancillary tests as facilitators to seeking ED care. One parent said, "...what I like is that they really are specialized in children—there are specialists in everything the child needs." Positive staff interactions and communication were also given as reasons to return to the ED.

Nearly every participant was concerned about long waits for emergency care, with some strategically choosing the time to go to the ED in order to minimize the projected wait. Being left in small exam rooms to wait a second time, the presence of other siblings, having a child in unaddressed pain, and having been advised to seek ED care by a nurse helpline worsened the frustration of waiting. As one parent noted, "Sometimes it is a lot of [waiting] time...sometimes it's not. One feels it is an eternity."

Triage based on illness rather than ED arrival time was a source of anxiety among parents. Parents recognized that sicker children were seen first, but they were nonetheless frustrated and anxious about the delay in their child's care. Several voiced concerns that the wait might have some basis in discrimination because of their ethnicity. One parent said, "They don't take the child who was there first...I don't know if it is because the [skin] color or something..." Parents were critical of occasional situations in which care was passed from one provider to another, requiring parents to start over with the history.

In general, families appreciated the professionalism of interpretation services provided. Language barriers were a concern when care was delayed while waiting for an interpreter or when staff proceeded with discussions about care in English.

Box 1. Behavioral Factors Identified by Parents of Latino Children With Nonurgent Emergency Department Visits

Key Concepts	Parent-Identified Constructs
Home treatment given prior to seeking emergency care	• Parents first managed symptoms at home. • Parents sought advice from relatives or friends; many called family outside United States for advice and treatment. • Recommended use of "home remedies" • Medicines were brought or sent from outside United States. • Some parents called the nurse line (in Spanish) at their clinic. • Users are satisfied. • Many parents were unaware of this resource. • Experienced parents were more willing to "wait it out."
Decision to seek medical care	• Parent perception of serious illness • Child's recurring fever following antipyretic use • Reduced child activity • Child not improving • Prior experience with perceived delay in care leading to death or serious impairment • Tradition to seek medical care
Decision to seek emergency care rather than seeing primary provider	• Facilitators • Avoid 2 long waits • Parent believes child will be more thoroughly examined and treated at the hospital emergency department. • Parent disagrees with clinic assessment of illness. • Parent feels that clinic serving Spanish-speaking families is "second tier" health care. • Barriers • Long wait in emergency department • Experience with emergency department making referral to Child Protective Services • Lack of provider continuity
Perceptions of emergency care	• High quality of care • Child thoroughly evaluated with clear diagnosis • Concern about being "passed over" for sicker children • Concern when sent home with "just Tylenol" instead of definitive therapy • Long wait times, particularly challenging with waiting with a sick child, who is uncomfortable or in pain • Concern that interpretation will delay care • Language barriers for some patients

DISCUSSION

Our study examined influences on parent decision making when seeking emergency care for nonurgent pediatric illness. Parents identified "push" factors related to dissatisfaction with primary care, being unaware of Spanish-language nurse call-in resources, and long clinic wait times. They also identified "pull" factors such as confidence in the thoroughness of care and heightened concern when a child had recurring fevers despite antipyretic use at home. It was clear that historical experiences and cultural expectations also influenced parental decision making. Nearly every family had tried to manage the child's illness at home prior to seeking medical attention, often employing a combination of medical and natural remedies. Families appreciated the language services offered in the emergency department and were especially grateful when on-site or telephonic interpretation did not delay care.

Studies of adults have suggested culture has little effect on the number of ED visits once variables such as age, health insurance coverage, and regular source of care are taken into account.[26,30] Satisfaction with primary care leads to a reduction in emergency utilization.[28,31] Factors that may influence families to bypass the clinic in favor of emergency care include transportation, office wait times,[10,32] language services, perceived quality, health insurance status, and after-hours telephone support.[15,21]

Our study and others have noted the frequent use of nonprescribed supplements and natural remedies among Latino patients, which they may not discuss with their physician.[33] These findings are a reminder to specifically enquire about all treatments in a receptive manner.[34] Most "home remedies" were benign, though there were worrying examples of medicines being sent from other countries and used on the advice of nonmedical professionals.

It was notable that nearly every parent had already been caring for their child's illness prior to coming to the ED. From the parents' perspective, they had often spent days trying to manage the child's illness at home and finally judged that the child's symptoms required professional assessment. Medical providers can use an ED visit as an opportunity to further educate parents about what reassuring signs they can expect. Providers could avoid minimizing cold symptoms, instead acknowledging them, giving reassurance that the child's body is fighting the infection, and discussing what the parent may do to make the child feel better. Clear expectations regarding the course of recovery along with worrisome signs/symptoms to watch for can act as a road map for the worried parent.

Family culture and previous experiences play a role in a parent's threshold to seek care. Parental use of the ED may also predict the child's use.[27,35] Families often hold misconceptions about the management of fever in children, often based on well-grounded fears and previous experiences with sickness under conditions of poverty and stress.[36-38] Several authors have argued for developing educational interventions to acknowledge parental

Box 2. Focus Group Moderator Prompts

Moderator Prompts

- When your child is sick, where do you go for medical advice?
- What other resources are available for questions regarding your child's health?
- Have you ever called your child's clinic or an after-hours resource line with a question about your child's health? Why not? What was your experience?
- What differences do you notice in the way you approach care for a sick child now compared to when you lived in another country?
- Have you had difficulties finding a doctor to take care of your child? If yes, describe some of these difficulties.
- What is the role of your child's clinic or doctor in the care of your sick child?
- What is the role of the emergency department in taking care of your sick child?
- When is it best to take your child to the emergency department for care?
- Thinking about your most recent emergency department visit, what makes you more likely to come back when your child is sick? What makes you less likely to come back?
- Thinking about a recent visit to your child's regular health clinic, what makes you more likely to schedule a visit when your child is sick? What makes your less likely?
- If you could change anything about your child's clinic to make it easier to get care for your sick child, what would it be?
- If you could change anything about the emergency department to make it easier to get care for your sick child, what would it be?
- Thinking about your child's health care overall, what problems do you see that make it harder to get care for your sick child at the clinic?
- Thinking about your child's health care overall, what problems do you see that make it harder to get care for your sick child at the emergency department?
- Finally, if you were in charge of making to changes to help parents get answers about how to care for their sick child, what changes would you make? What changes would you make to where parents seek care for their sick child?

concerns and give reassurance and guidance.[17,37,39]

Parents were eager to learn more about how to care for their child, and there was enthusiasm for opportunities to learn more about child health.[39] The availability of Spanish-language telephone triage could be advertised in clinics and might reduce unnecessary medical visits.

Lengthy waits for care were a source of frustration for all patients. Parent concerns were compounded by language 'barriers'[40] and their observation that some patients were cared for ahead of their own child. Frequent updates, on-demand telephonic interpretation, and improved communication may alleviate concerns of being forgotten. Reducing family idle time spent in the exam room could also decrease the perceived wait.

There are several limitations to our study. We only included children with an identified primary care provider; therefore, these findings do not apply to uninsured families who turn to the ED as a provider of last resort. Most participants were of Mexican origin, mirroring the distribution of Latino families in Washington State. We enrolled families who received pediatric ED care at a single institution, and thus findings may not generalize to other institutions. Some themes may have been difficult to discuss in the focus group setting, such as immigration status. We identified nonurgent care by examining children who did not require ED tests, admission, or imaging. We did not exclude medication utilization, as this would have eliminated many children seen for fever and cold symptoms who were simply treated with acetaminophen or ibuprofen. Nonetheless, the definition of *nonurgent* depends on medical and family circumstances, cultural experience, and parental perspective.

This study elucidated factors influencing Latino parents' decision to seek emergency care for nonemergent health conditions. Each parent had attempted to manage the child's illness at home but became concerned that home management had failed, presenting opportunities for improved education on the management and time course of febrile illness and hydration. There was widespread use of informal consulting networks and traditional treatments, most of which were not discussed with medical personnel. Families were eager for Spanish-language information on managing illness, and many were unaware of nurse triage call lines. Reducing clinic wait times for acute illness visits and offering extended clinic hours are steps which may reduce nonemergent ED use. Ultimately, we hope these findings suggest opportunities to redirect nonurgent care to the primary provider and will strengthen the connection with the child's medical home.

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