

Reasons for Emergency Department Use: Do Frequent Users Differ?

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The number of emergency department (ED) visits in the United States has grown dramatically over the past 15 years, from 93.1 million annual visits in 1996 to 129.5 million visits in 2011.¹ Rather than being equally distributed across the population, approximately 5% of patients who use the ED are responsible for 25% of all ED visits.² Termed frequent users, these patients are of interest to policy makers due to the high healthcare costs they incur both in the ED and in other parts of the healthcare system.

Prior studies have examined basic characteristics of frequent ED users, using definitions of frequent use varying from 2 to 20 or more ED visits per year.³ Research has shown that, in contrast to common assumptions, frequent ED users are sicker than the general population and often have multiple health problems.^{2,4,5} Furthermore, they tend to have higher ED triage acuities and hospital admission rates than other patients.^{2,6,7} Most frequent users are insured, and they utilize outpatient clinics in addition to the ED.^{2,8-15} Studies have identified many correlates of frequent ED use including specific medical conditions, mental illness, and type of insurance, among others.^{2,3,16}

Amid the literature on frequent ED users, however, there has been almost no prior research exploring reasons that frequent ED users give for using the ED. One qualitative study of a small group of frequent ED users identified themes such as lack of timely primary care provider availability and feeling that ED services were needed.¹⁷ Multiple past studies have examined reasons for ED use among patients more generally, regardless of level of prior ED use. These studies have paid particular attention to patients deemed to have visited the ED for so-called “nonurgent” or “inappropriate” reasons,¹⁸⁻²³ even though no consensus exists on how to define these visits and such categorizations are fraught with difficulty.²⁴⁻²⁶

Some of the more common reasons found in prior research for why patients use the ED were believing their problem re-

ABSTRACT

Objectives

To examine patients' reasons for using the emergency department (ED) for low-acuity health complaints, and determine whether reasons differed for frequent ED users versus nonfrequent ED users.

Study Design

Prospective cross-sectional survey.

Methods

Patients presenting to an urban public hospital for low-acuity health complaints were surveyed about their reasons for visiting the ED rather than a private doctor's office or clinic. Patients with 3 or more visits to the study hospital ED over the past year were classified as frequent ED users. Multivariable logistic regression was used to determine if frequent ED users gave different reasons for ED use than nonfrequent ED users, while controlling for differences in other baseline patient characteristics.

Results

940 patients, including 163 frequent ED users, completed the study questionnaire. Commonly cited reasons for using the ED were that coming to the ED was easier than making a clinic appointment (82.3% agreed); the problem could not wait (78.8%); they didn't know how to make a clinic appointment (66.7%); they felt the ED provided better care (56.7%); and they believed the clinic would cost more (54.8%). After controlling for other patient characteristics, there were no significant differences found in reasons for ED use given by frequent versus nonfrequent ED users.

Conclusions

Frequent ED users gave similar reasons for using the ED for low-acuity health complaints compared with nonfrequent ED users. Access, convenience, cost, and quality concerns, as well as feeling that ED care was needed, were all commonly cited as reasons for using the ED.

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quired ED care,^{19,22,23,27-31} lacking accessible primary care alternatives,^{19,21,22,32} not being able to make expedient outpatient appointments,^{19,23,27,33-35} and trusting the ED more than other sites.^{22,31,36} Studies have not explored differences in reasons for ED use given by frequent versus nonfrequent ED users, leaving a significant gap in the existing literature and providing no clear direction for policy makers. In the current study, we used a cross-sectional survey of low-acuity patients presenting to an urban public hospital ED to determine patients' reasons for ED use and to examine whether frequent ED users report different reasons compared to nonfrequent users.

METHODS

Study Design and Setting

This study uses results from a cross-sectional survey conducted as part of a larger trial.³⁷ In brief, the trial examined the impact of an intervention offering ED patients with low-acuity complaints the opportunity to forgo their ED visit and instead receive same-day care in a primary care clinic in the same hospital building as the ED. The study was conducted at Bellevue Hospital Center, a public safety net hospital in New York City, whose ED has 100,000 patient visits yearly. The study was approved by the institutional review boards at New York University School of Medicine and Bellevue Hospital Center.

Patient Enrollment and Classification

Patients were considered for inclusion if they presented to the ED with selected presenting complaints that a layperson would be expected to recognize as low-acuity. These were: sore throat; medication refill; nontraumatic joint or back pain; symptoms of a simple urinary tract infection; symptoms of a cold or upper respiratory infection; or a stable chronic medical illness of headache, hypertension, or diabetes. All patients were 23 years or older, as younger patients are served by a pediatric ED. Patients arriving by ambulance were excluded, as were patients with a temperature greater than 38.3°C. Patients were also excluded if the triage nurse felt the individual required ED care (for example, if the nurse felt the patient had complex coexisting conditions that made transfer to the clinic unsafe or was otherwise not clinically stable for transfer to the clinic). Though, in practice, the triage nurses rarely overruled study enrollment, study investigators felt that including this provision of triage nurse discretion

Take-Away Points

Frequent emergency department (ED) users are of concern to insurers, healthcare systems, and policy makers because they account for a disproportionately large share of ED visits and costs. We studied patients' reasons for using the ED for low-acuity health complaints, comparing frequent versus nonfrequent ED users.

- Frequent and nonfrequent ED users gave similar reasons for using the ED.
- Common reasons for ED use included concerns about convenience, timely access, quality, and costs.
- Health systems must examine whether reasonable alternative options to the ED exist and are responsive to patients' needs and desires, rather than penalizing so-called "inappropriate" ED use.

was important in providing an additional layer of safety to the intervention. Enrollment was conducted from January 2007 to January 2008 on weekdays from 9 AM to 3 PM when the hospital's primary care clinic was open and available for patients. Patients could only be enrolled in the study once.

Patients were enrolled regardless of previous ED utilization and were then divided into "frequent users" and "nonfrequent users" for the analysis using ED visit data obtained from hospital administrative databases. We categorized patients as frequent users if they had made ≥ 3 visits to the study hospital ED over the prior year (including the study enrollment visit). No agreed-upon standard for how many prior visits defines "frequent" ED use exists in the literature or practice; we chose the 3 visits per year because this threshold has been commonly used in previous studies.² Though all baseline visits were for low-acuity health complaints, prior ED visits could have been for any reason.

Data Collection and Measures

Research associates administered a baseline questionnaire to all patients. This questionnaire permitted the collection of demographic and health information (eAppendix A, available at www.ajmc.com) and included a series of 10 questions about patients' reasons for visiting the ED that day rather than a private doctor's office or clinic (Figure). Questions were developed via consensus by a group of emergency and primary care clinicians based on review of prior literature and observations from clinical practice. The questionnaire was pilot-tested in the ED prior to beginning the study to ensure question clarity and patient comprehension. Each question gave a reason why one might use the ED rather than a clinic and asked patients whether they agreed or disagreed that this reason influenced their own decision to use the ED that day. Questionnaires were administered verbally. Dual-headset translation phone systems were used for non-

■ Figure. Patient Questionnaire

Patients have told us some of the reasons that they decided to come to the Bellevue Emergency Room. They may have thought about going to see a doctor in a clinic or a private office, but they had decided to come to the Emergency Department. For each of these statements, tell us whether you also thought about these today. (Answers are "agree" and "do not agree.")

1. My problem today could not be treated by a doctor in a clinic or in a private office. ____
2. I thought I needed tests (for example, blood tests and x-rays) that a doctor in a clinic or in a private office would not be able to do. ____
3. I thought that I was going to have to be admitted to the hospital to take care of my medical problem. ____
4. Coming to the Emergency Department today was easier than trying to make an appointment to see a doctor in a clinic or in a private office. ____
5. My problem could have been treated in the Bellevue Primary Care Clinic, but I didn't know how to make an appointment to see the doctor. ____
6. I would have gone to see a private doctor or a clinic, but my problem could not wait to see the doctor tomorrow or the next day. ____
7. The hospital is a big business and does not care whether I pay the bill or not. ____
8. A clinic would want me to pay today for the visit with the doctor. ____
9. A visit to a private doctor or clinic would cost more than I will have to pay for a visit to the Emergency Department. ____
10. Even if a medical problem could be taken care of in a doctor's office or a medical clinic, a patient would get better care in the Emergency Department.

English speaking patients. Written informed consent was obtained from all patients.

Data Analysis

Simple means and proportions are presented for baseline characteristics of frequent and nonfrequent ED users. Bivariate relationships between frequent use and reason for ED use were examined using χ^2 tests. Multivariable logistic regression was used to examine the independent effect of being a frequent ED user on likelihood of agreeing with each reason for ED use while controlling for other differences in baseline patient characteristics. Control variables included age, sex, race/ethnicity, language, education, employment, insurance, chief complaint, overall health, whether the patient reported having a personal doctor, and prior use of the hospital's primary care clinic. These control variables were chosen because prior studies have found these factors to be related to the likelihood of using the ED for care and of being a frequent ED user.^{2,21} All control variables were based on self-report except for prior primary care clinic use, which was ascertained from hospital administrative databases.

Exploratory factor and principal components analysis found no condensed set of factors that adequately captured the correlation and variance among individual reasons for ED use (full correlations are shown in [eAppendix B](#)). Therefore, 10 separate multivariable logistic regressions were conducted, each using a different reason-for-ED-use question as the dependent variable. All control variables were retained in the multiple logistic regression models based on theory and to avoid omitted variable bias.^{38,39} Model goodness of fit was confirmed with Hosmer-Lemeshow tests. All analyses were conducted using SAS 9.2 (Cary, North Carolina).

RESULTS

Of the 1404 patients eligible for the study, 439 declined to participate and 965 agreed and were enrolled. Twenty-five patients were excluded from the analysis because they had not completed any of the questions regarding reasons for ED use. Thus 940 patients were included in the current analysis, including 163 who had made ≥ 3 ED visits over the prior year and were categorized as frequent users.

■ **Table 1.** Baseline Patient Characteristics by Group, n (%)

	Frequent Users (n = 163) ^a	Nonfrequent Users (n = 777)
Age in years, mean (SD)	49.3 (11.6)	46.2 (13.8)
Male	100 (61.7)	445 (57.4)
Uninsured	119 (73.0)	356 (45.8)
Unemployed	122 (74.9)	487 (62.7)
No personal doctor	80 (49.1)	525 (67.7)
Prior use of hospital primary care clinic	86 (52.8)	132 (17.0)
Ethnicity		
Black	57 (35.2)	181 (23.4)
Latino	50 (30.9)	344 (44.4)
White	25 (15.4)	103 (13.3)
Asian	20 (12.4)	112 (14.5)
Other	10 (6.2)	35 (4.5)
Education		
Less than eighth grade	31 (19.1)	195 (25.4)
Some high school	30 (18.5)	110 (14.3)
High school or GED	50 (30.9)	239 (31.1)
Some college	31 (19.1)	98 (12.8)
College and beyond	20 (12.4)	126 (16.4)
Primary language		
English	97 (59.5)	324 (41.8)
Spanish	38 (23.3)	273 (35.2)
Other or bilingual	28 (17.2)	178 (23.0)
Self-rated health		
Poor	29 (17.8)	116 (14.9)
Fair	44 (27.0)	239 (30.8)
Good	56 (34.4)	280 (36.0)
Very good/excellent	34 (20.9)	142 (18.3)
Chief Complaint		
Back or joint pain (nontraumatic)	49 (30.6)	294 (39.1)
Chronic illness	12 (7.5)	77 (10.2)
Cold symptoms	16 (10.0)	107 (14.2)
Medication refill	60 (37.5)	157 (20.9)
Sore throat	12 (7.5)	65 (8.6)
Urinary symptoms	11 (6.9)	52 (6.9)
^a Due to variable response rates for each question, actual denominators differ slightly per row (missing data <5%).		

The mean age was 49 years for frequent users and 46 years for nonfrequent users (Table 1). Approximately 60% of patients in each group were male; most patients were Latino or black. More frequent than nonfrequent users identified English as their primary language (59.5% vs 41.8%). Frequent users were more often uninsured (73% vs 45.8%), yet were more likely to have a personal doctor (50.9% vs 32.4%) and to have used the hospital's primary care clinic in the past year (52.8% vs 17%).

Overall, the most commonly endorsed reason for using the ED was that coming to the ED was easier than making a clinic appointment, with 82.3% of patients agreeing with this statement (Table 2). Patients also frequently agreed that they would have gone to a clinic but their problem could not wait until tomorrow or the next day (78.8%) and that their problem could have been treated in a clinic but they did not know how to make an appointment (66.7%). More than half also agreed that patients would get better care

■ **Table 2.** Reasons for Emergency Department (ED) Use—Patients Who Agreed With Each Statement, n (%)

	Overall (n = 940) ^a	Frequent User (n = 163)	Not Frequent User (n = 777)	P ^b
Felt ED care was needed				
Problem could not be treated in a clinic	405 (44.0)	72 (45.3)	333 (43.8)	.725
Thought needed tests a clinic could not do	444 (48.0)	61 (37.9)	383 (50.1)	.005
Thought would have to be admitted	336 (36.9)	57 (35.6)	279 (37.2)	.708
Convenience				
Coming to the ED was easier than making a clinic appointment	764 (82.3)	129 (80.1)	635 (82.8)	.420
Access				
Problem could have been treated in a clinic, but did not know how to make an appointment	615 (66.7)	93 (57.8)	522 (68.6)	.008
Would have gone to a clinic, but problem could not wait until next day	730 (78.8)	119 (74.4)	611 (79.7)	.137
Costs				
A clinic would want me to pay today	504 (54.8)	74 (46.3)	430 (56.7)	.016
A visit to a clinic would cost more than the ED	487 (53.1)	83 (51.9)	404 (53.4)	.731
The hospital does not care whether I pay the bill	179 (19.4)	29 (18.0)	150 (19.7)	.616
Quality				
A patient would get better care in the ED	525 (56.7)	85 (53.5)	440 (57.4)	.366

^aDue to variable response rates for each question, actual denominators differ slightly per row (missing data <5%).
^bP value for χ^2 test of difference between frequent users and nonfrequent users.

in the ED (56.7%), a clinic would want them to pay today (54.8%), and a clinic visit would cost more (53.1%). Somewhat fewer patients reported that a clinic could not treat their problem, that they needed tests that a clinic could not do, or that they needed to be admitted to the hospital.

Frequent and nonfrequent ED users gave similar reasons for using the ED (Table 2). The only significant differences observed in bivariate analyses were that frequent users were less likely to think they needed tests that a clinic could not do (37.9% vs 50.1%), less likely to feel that their problem could have been treated in a clinic but that they did not know how to make an appointment (57.8% vs 68.6%), and less likely to say that a clinic would want them to pay today (46.3% vs 56.7%). After adjusting for differences in baseline patient characteristics, no significant differences were observed between frequent and nonfrequent ED users in reasons for using the ED (Table 3).

DISCUSSION

Frequent and nonfrequent ED users endorsed similar reasons for using the ED rather than a clinic or private doctor's office for low-acuity health complaints. In both groups, the most common factors influencing ED use were convenience and feeling that their condition was urgent and could not wait. Though we considered the latter

reason an access factor because it implied lack of availability of same-day clinic appointments, it could also be considered a factor related to urgency and patients' beliefs that ED care was needed. Indeed, considering that only patients with selected low-acuity health complaints were included, a surprising number of patients felt that their condition required ED care. This finding underscores the difficulty that patients have in assessing the seriousness of their condition and, along with recent research confirming the challenges of correctly classifying "nonemergency" conditions,²⁶ highlights the potential dangers of efforts to turn away patients from the ED who have so-called "non-urgent" health conditions.

Americans are increasingly using the ED for their acute care needs rather than visiting personal physicians.⁴⁰ In fact, 28% of the 354 million outpatient visits for acute care made in the United States between 2001 and 2004 were made to EDs.⁴⁰ Examining why patients choose to use EDs is important in understanding this trend, which is viewed as troubling by policy makers, insurers, and others. Indeed, much national attention is focused on efforts to decrease ED use, particularly for conditions judged to be "nonurgent." Such efforts are often driven by assumptions that ED care for nonurgent conditions is costly and drives ED crowding, despite the fact that neither of these assumptions is clearly supported by existing research.⁴¹⁻⁴³

■ **Table 3.** Multivariable Logistic Regression, Frequent Versus Nonfrequent Emergency Department (ED) Users

Reason for ED Use	Adjusted Odds Ratio (95% CI)
Felt ED care was needed	
Problem could not be treated in a clinic	1.14 (0.77-1.69)
Thought needed tests a clinic could not do	0.78 (0.52-1.16)
Thought I would have to be admitted	1.40 (0.90-2.17)
Convenience	
Coming to the ED was easier than making a clinic appointment	0.91 (0.55-1.48)
Access	
Problem could have been treated in the clinic, but did not know how to make an appointment	0.79 (0.53-1.17)
Would have gone to clinic, but problem could not wait until next day	0.68 (0.43-1.10)
Costs	
A clinic would want me to pay today	0.95 (0.64-1.40)
A visit to a clinic would cost more than the ED	1.25 (0.84-1.85)
The hospital does not care whether I pay the bill	0.92 (0.55-1.53)
Quality	
A patient would get better care in the ED	1.07 (0.71-1.60)
Covariates included: insurance status, education, language, employment status, race/ethnicity, sex, age, overall health, chief complaint, prior PMD (primary medical doctor) use, and prior clinic use. Model C statistics range from 0.60 to 0.75.	

Cost savings that could be achieved from diverting a portion of nonurgent ED visits may be lower than commonly expected.⁴⁴ On the other hand, by utilizing EDs rather than primary care clinics, patients may suffer from more fragmented care and lose additional benefits of primary care such as preventative screenings and health maintenance services. In addition, a recent RAND report revealed that an increasing proportion of all hospital admissions are occurring through EDs, indicating that there may be important downstream consequences and costs to consider when evaluating increasing ED visit rates.⁴⁵ The focus on reducing ED use is likely to continue with the expansion of new payment and healthcare delivery models (such as accountable care organizations) that incentivize population health rather than pay for volume of services.

Though the current study is the first to have compared self-reported reasons for ED use by frequent versus nonfrequent ED users, past studies have examined reasons for ED use among ED patients overall. Results of the current study were generally consistent with those of prior research. A recent systematic review concluded that common reasons for nonurgent ED use were convenience, perceived urgency of the presenting condition, being referred by other healthcare providers, and feeling that one would receive better care in the ED.²³

Though not focused on nonurgent use, one of the largest studies to examine patients' reasons for using the ED

was the Emergency Medicine Patients' Access to Healthcare (EMPATH) study, a cross-sectional survey of 1579 patients at 28 US EDs.³¹ In this study, the most commonly cited reasons for using the ED were perceived necessity of ED care, convenience, and preference for the ED.³¹ Affordability was cited less often than observed in the current study,³¹ which could be due to the fact that patients in the current study were more homogeneously low-income. A recent qualitative study among low-income patients in Philadelphia found cost to be an important reason why patients preferred hospital care over ambulatory care, along with perceptions of hospital care as more accessible and of higher quality.⁴⁶

The EMPATH study authors concluded that "Use of the ED is, for most people, an affirmative choice over other providers rather than a last resort."³¹ The current study likewise found that many of the reasons given by patients for using the ED for a low-acuity health complaint could be considered an "affirmative choice," albeit a choice in the context of significant limitations in other existing options. It is unclear whether patients would make the same choices, for example, if presented with an option of same-day affordable clinic care. Nonetheless, patients appear to be making a decision—to access timely care that they perceive as high quality, necessary, and affordable—that is quite reasonable within the current context of available healthcare options. It should not be surprising that pa-

tients value quality healthcare that is easy to access when they want it.⁴⁷ Most primary care practices offer limited evening and weekend hours, and patients often need to wait days or even weeks before getting an appointment. Such barriers to primary care access exist even among patients with insurance and are associated with increased ED use.⁴⁸

Rather than blaming patients for “inappropriate” ED visits, it may be more effective to instead structure a healthcare system that is responsive to patients’ desires for timely, high-quality, convenient acute care and to determine whether viable options apart from the ED exist or are feasible and cost-effective to implement. Future research and policy experiments have the opportunity to evaluate how care delivery can be improved by thoughtful and rational redesign of existing systems, prioritizing consumer preferences, and accounting for the increasing influence of capitated plans. In addition, critical thought is needed about whether in certain cases the ED may indeed be the most appropriate site for acute care, even for presumably low-acuity health conditions.

Limitations

The study was conducted among ED patients at a single urban safety net hospital with a co-located primary care clinic, and results may not be generalizable to patients at other hospitals. We did observe that patients in the current study gave similar reasons for using the ED as those found in previous studies with different populations. Second, some patients who were considered “non-frequent users” might have had additional ED visits at other hospitals, which, if considered, would have resulted in their classification as “frequent users.” Though some misclassification may have occurred, the “frequent users” in the study likely also had ED visits outside the study hospital; thus, there would still exist a relative gradient in ED use between those patients classified as frequent and nonfrequent ED users.

In addition, frequent users in this study may not be generalizable to other frequent users nationwide. First, the definition used for “frequent users” of 3 or more ED visits per year was relatively liberal. We did, however, conduct exploratory analyses using cut-offs of 4 or more and 5 or more ED visits per year and found similar results. Nonetheless, it is possible that even more extreme frequent ED users might have different reasons for ED use. Given the small number of patients in the current study with such high levels of ED use, this sort of analysis was not feasible. Second, patients were only enrolled during ED visits for specific low-acuity complaints, which may have resulted

in capturing a subset of frequent ED users who differ from frequent ED users overall. The study findings are still useful, but one must exercise caution in generalizing to all frequent ED users—which is itself a heterogeneous group—given these limitations.

A third study limitation was that the questionnaire on reasons for ED use had not been previously validated. It is unclear how and if this would have influenced the results. If patients had been asked to give the one most important reason for visiting the ED, rather than being allowed to select multiple reasons, results may have differed; future studies asking patients to quantify or rank their reasons for ED use may enhance our understanding. It is also possible that we did not detect differences in reasons for ED use between frequent and nonfrequent ED users due to a combination of having a relatively small sample size and using a nonvalidated questionnaire. Thus, the results presented here should be viewed with appropriate caution and warrant further study.

Finally, patients were enrolled only on weekdays during hours when the study hospital’s primary care clinic was open, and only patients presenting for low-acuity complaints were eligible for inclusion. Some patients, such as those who are employed during the daytime and potentially more likely to present for low-acuity conditions in the evenings or on weekends, would be underrepresented by our enrollment strategy. One might believe that this focused enrollment is a limitation of the current study. However, we feel that the enrollment strategy was actually a strength because it allowed for a focus on those patients who are of most interest: namely, those who potentially could have used a clinic rather than the ED for their healthcare at the time of presentation.

CONCLUSIONS

Frequent and nonfrequent ED users presenting to an urban ED gave similar reasons for using the ED rather than a clinic or private doctor’s office for their low-acuity health complaints. Frequent ED users gave logical reasons for their ED use, and many had primary care physicians. The most frequently endorsed reasons for ED use encompassed real or perceived barriers to easily accessing timely clinic care, which could in theory be corrected with changes in the outpatient delivery system. Policy makers and others attempting to discourage ED use should consider patients’ reasons for using the ED and take into account the structure of the healthcare delivery system as a whole to design programs and systems that are responsive to patients’ needs.

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eAppendix A. Baseline Questionnaire

Patients were asked for standard demographic information including age, gender, employment status (currently employed or currently unemployed), current insurance type (grouped as insured or uninsured for the analysis), race/ethnicity (grouped as white, black, Latino, Asian, or other for the analysis), education (grouped as less than 8th grade, some high school, high school or GED, some college, or college and beyond for the analysis), and language spoken in the home (grouped as English, Spanish, or other for the analysis). Patients were also asked whether they had a personal doctor, defined as “[a doctor] you would see if you need a check-up, want advice about a health problem, or get sick or hurt,” and to rate their overall health as poor, fair, good, very good, or excellent, using a question modified from the validated Short Form-12 health status questionnaire.¹ Responses of very good and excellent were combined for the analysis. A patient’s chief complaint was obtained from triage paperwork, and prior hospital primary care clinic use in the past year was ascertained from hospital administrative records and categorized as any or none for analysis.

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¹Ware J Jr, Kosinski M, Keller SD. A 12-Item Short-Form Health Survey: construction of scales and preliminary tests of reliability and validity. *Med Care*. 1996;34(3):220-233.

eAppendix B.

Correlations	Kendall's tau_b	1. My problem could not be treated in a clinic	2. Thought needed tests that a clinic could not do	3. I thought I would have to be admitted to the hospital	4. Coming to the ER is easier than making a clinic appointment	5. My problem could have been treated in the clinic, but I did not know how to make an appointment	6. I would have gone to a clinic, but my problem could not wait to see a doctor tomorrow or the next day	7. The hospital does not care whether I pay the bill or not	8. A clinic would want me to pay today	9. A visit to a clinic would cost more than the ER	10. A patient would get better care in the ER
1. My problem could not be treated in a clinic	Correlation Coefficient	1.000	.441	.247	.086	.053	.137	.171	.043	.158	.241
2. Thought needed tests that a clinic could not do	Correlation Coefficient	.441	1.000	.313	.147	.147	.109	.170	.156	.187	.257
3. I thought I would have to be admitted to the hospital	Correlation Coefficient	.247	.313	1.000	.114	.164	.106	.304	.119	.226	.254
4. Coming to the ER is easier than making a clinic appointment	Correlation Coefficient	.086	.147	.114	1.000	.136	.176	.089	.073	.160	.158
5. My problem could have been treated in the clinic, but I did not know how to make an appointment	Correlation Coefficient	.053	.147	.164	.136	1.000	.133	.128	.139	.140	.074
6. I would have gone to a clinic, but my problem could not wait to see a doctor tomorrow or the next day	Correlation Coefficient	.137	.109	.106	.176	.133	1.000	.105	.100	.020	.077
7. The hospital does not care whether I pay the bill or not	Correlation Coefficient	.171	.170	.304	.089	.128	.105	1.000	.145	.276	.244
8. A clinic would want me to pay today	Correlation Coefficient	.043	.156	.119	.073	.139	.100	.145	1.000	.311	.107
9. A visit to a clinic would cost more than the ER	Correlation Coefficient	.158	.187	.226	.160	.140	.020	.276	.311	1.000	.266
10. A patient would get better care in the ER	Correlation Coefficient	.241	.257	.254	.158	.074	.077	.244	.107	.266	1.000