Published in final edited form as:

Am J Med Sci. 2016 April ; 351(4): 400–406. doi:10.1016/j.amjms.2016.01.007.

Contested Ownership of Disease and Ambulatory Sensitive Emergency Department Visits for Type 2 Diabetes

Jennifer E. Shearer, PhD, RN, CNE [Assistant Professor],

College of Nursing, Medical University of South Carolina

Carolyn H. Jenkins, DrPH, MS, MSN, RD, LD, FAAN [Professor],

Medical University of South Carolina

Gayenell S. Magwood, PhD, RN [Associate Professor], and

Medical University of South Carolina

Charlene A. Pope, PhD, MPH, RN, FAAN [Associate Professor]

Medical University of South Carolina, Ralph H. Johnson VA Medical Center, Charleston, South Carolina

Abstract

Background—About 21 million persons have diabetes and account for 11.9% of all emergency department visits for a total cost of \$14.1 billion. Non-emergent visits for ambulatory sensitive conditions that could be managed by the primary care provider make up almost one third of the ED visits. African Americans comprise about 30% of South Carolina's population but make up about 50% of the ED visits for diabetes.

Methods—The research design was a qualitative study using grounded theory with dimensional analysis methods to explore reasons African American patients used the ED for ambulatory sensitive conditions.

Research Design—The research design for this study is grounded theory with dimensional analysis methods to explore the experiences of 20 African American adults with diabetes with ambulatory sensitive ED use. Following informed consent, interviews were recorded and transcribed verbatim, and themes were analyzed to form the explanatory framework or matrix for ED use. The framework of context, conditions, processes, and consequences provides a key for understanding the themes of the story embedded in the descriptive narratives

Results—The contested ownership of diabetes was the overarching perspective —“doing what I got to do,” “it's always on mind...wishing not to be a diabetic,” and “it's a constant burden.” And handling diabetes involved taking decisions “into your hands.” The context of perceived urgency of symptoms included all the reasons that precipitated ED visit—personal experience, primary

Corresponding Author: Carolyn Jenkins, Medical University of South Carolina, 99 Jonathan Lucas Street, MSC 160, Charleston, SC 29425, jenkinsc@musc.edu, Telephone: (843) 792-4625.

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

care access and services, and social network support for decisions influenced ownership of these decisions.

Keywords

Type 2 Diabetes; Emergency Department use; Ambulatory sensitive conditions; Qualitative Research; Grounded Theory with Dimensional Analysis

Approximately 29.1 million people or about 9.3% of the population in the United States have diabetes and of those, about 21 million are diagnosed with diabetes and account for 11.9% of all emergency department visits for a total cost of \$14.1 billion^{1,2}. The annual per capita cost attributed to emergency department (ED) visits is \$299 for each person with diabetes³. A recent study by Galarraga and Pines⁴ reported that non-emergent visits for ambulatory sensitive conditions from all causes comprised 30.4% of all ED visits and 10.6% of ED costs. Ambulatory sensitive conditions are conditions that are preventable through appropriate ambulatory care but these conditions often contribute to ED use and hospitalizations⁴. Because ED visits are a more costly delivery method than care delivered in a primary care setting, treatment through the ED has been characterized as an indicator of poor quality for diabetes care³. Nationally, African Americans are one of the higher ED user groups with an estimated 80 visits per 100 persons⁵. In South Carolina, where this research study took place, African Americans comprise about 30% of the population, yet account for over 50% of the ED visits for diabetes, and more than two thirds of all nonemergent visits, with numbers that continue to increase⁶.

Understanding Decision Making around Ambulatory Sensitive ED Visits

Though most of these ambulatory sensitive visits for diabetes care could be better managed with significantly lower costs in primary care, ED use might also signal barriers to access and a lack of acceptable options in the community⁷. The under-investigated perspectives of African Americans with diabetes who used the ED merited a qualitative study approach that permitted open-ended discovery of the reasoning, beliefs, fears and experiences within the event. In the construction of the assumptions, qualitative research question, approach to participants, and generation of the interview questions, we employed the tradition of constructivist grounded theory in the study design⁸. We used dimensional analysis for constructing a particular reality as first described by Schatzman⁹. This approach shapes the process of analysis in decisions made for coding, attributes, processes, contexts, conditions, properties, and consequences. Dimensional analysis of grounded data is described first as designating, then differentiating into categories, and finally integrating the dimensions with an overarching perspective, looking for fit and avoiding exceptions¹⁰.

Purpose

Although predictors for ambulatory sensitive use of the ED for general diagnoses have been examined^{11,12}, there is less information from the perspective of the patient about reasons for seeking ambulatory sensitive care of diabetes in the ED. Our specific aims in this qualitative study were to examine decision-making processes used by African Americans with type 2

diabetes mellitus (T2DM) when seeking ambulatory sensitive care through hospital EDs in a southeastern state and to present a conceptual framework that describes this process.

Methods

Research Design

In the tradition of Schatzman⁹, grounded theory methods with dimensional analysis of data were used to uncover the process of decision making about ED use and contribute to a substantive theory of this experience. As the basis of grounded theory¹³ and dimensional analysis that seeks an understanding of how people make sense of their experience⁹, symbolic interactionism shapes the approach used to explore the phenomenon of making the decision to use the ED. People's interactions can be understood from their own articulation of it and grounded theory proposes an explanation from the patterns and variations expressed¹⁴. Rather than looking for the basic social process, Schatzman's method searches all dimensions of the perspective and context. Like any story, the narrative will have an overarching perspective, a theme that links what happens in the context of conditions in a logical explanation of resulting consequences. The process of ED use for ambulatory conditions is context specific and self-management of diabetes in context is a promising area for understanding diabetes service use¹⁵. As a result, we propose a conceptual framework of the process of making ambulatory sensitive ED visits. Describing all that is happening in an experience can uncover processes not previously studied¹⁰.

Participant Selection

The Institutional Review Board (IRB) of the participating university reviewed and approved all procedures prior to participant recruitment and enrollment. Participants were provided and signed informed written consent. To guide the collection of data, we used purposive sampling to interview participants who had been treated in a local ED of a large academic health system within 30 days prior to the interview. Two out of 24 potential participants refused to participate, one "going out of town" and the other "not able to participate, too busy." The researchers were unable to contact one participant (telephone and address changed or incorrect) and one was excluded because she requested help from the research nurse and social services intervened. All had a diagnosis of T2DM and the presenting problems and discharge diagnoses were considered ambulatory sensitive. Potential participants with admission/discharge codes indicating T2DM were recruited by referral from the ED nurses or inpatient diabetes educator (with signed permission from patient to refer to the researcher). Twenty adults participated in the study.

Data Collection

Initial interviews were conducted and audio-recorded in the participant's home by a same race nurse interviewer. The semistructured interviews were conducted over a period of nine months and participants received \$50 at the conclusion of the interview. An interview guide was developed by the researchers, pilot tested by community health workers, refined by the research team, and then approved by the IRB of the university. Interviews were structured around six open-ended questions: How did you make the decision to seek emergency care? Who assisted or supported you in making the decision? What do you think caused the

problem? What kinds of activities occurred prior to going to the ED? What type of care did you receive at the office? How do you manage your diabetes? Field notes were guided by a semistructured format with secondary prompts. Each interview lasted approximately one hour and was transcribed verbatim. Notes were reviewed shortly after completing the interview. In an effort to gain clarification of transcripts and verification of findings, the interviewer followed-up by telephone with three participants to review questions and validate researcher conclusions.

Results

Data Analysis

The age of participants ranged from 30-88 years. Household income ranged from \$800 to \$8,000 per month, whereas household size ranged from one to six persons. Health care coverage included Medicaid and Medicare (n = 10), private insurance (n = 7) or no insurance (n = 5). Notably, some participants had both Medicare and private insurance, usually a Medi-gap policy.

Transcribed narrative data were entered into QSR International's NVivo 8¹⁶ software for analysis and coded by one of the authors. Schatzman's⁹ dimensional analysis method was used to analyze interview data. This method entails coding by designating dimensions of attributes by descriptive phrases. In an attempt to capture all that was happening, many phrases were designated with codes until a collection of coding appeared saturated with dimensions. For example, under the problem leading to ED use, participants related dimensions of loss: loss of consciousness, loss of sight, loss of a favorite doctor, and loss of access to primary care. Access codes also included a range of dimensions from access by transportation to access affected by attitudes toward providers. Dimensions of primary care access and services included waiting for an appointment, waiting in the office, missing appointments, lacking a consistent doctor, and being told to go to ED by a physician. The resulting mass of data included some redundancy and less relevant themes that were subsumed in other dimensions or considered later. Themes were differentiated into categories and configured into a framework that provided structure for the narrative explanation (Table 1).

One overarching theme provided a perspective that organized the placement of other dimensions giving the narrative a framework. Interpretation of what is happening is dependent on the perspective and attention must be given to its selection. The selection of the overarching perspective evolved after trying many dimensions from the framework for an explanation in the narrative. For example, primary care access and service issues were tried as the overarching perspective but having access did not explain the social network support used to make decisions about self-management. Constancy explained only those who were dealing with problems but not controlling them. Eventually, the concept of contested ownership emerged as a standpoint where the disease was positioned as either central to one's identity or a constant external threat to be dealt with. These two competing standpoints were chosen to integrate the remainder of the components into a narrative for explaining ambulatory sensitive ED visits by the study population. The context, conditions, processes

and consequences that emerged from participant accounts reflected how decision making vacillated, or were actively contested between these perspectives of disease ownership.

Report of Findings

The explanatory framework (Table 1) provides structure to the narrative guided by the one perspective antecedent to all other possible explanations, as the tradition of dimensional analysis recommends⁹. Thus, the narrative explains what is happening for each case, including the negative cases and outliers within that context. The framework of context, conditions, processes, and consequences provides a key for understanding the themes of the story embedded in the descriptive narratives⁹.

Overarching perspective: Contested ownership of diabetes—Contested ownership of disease was the one idea that explained the narrative of “doing what I got to do,” and guided what was happening in the decision to use the ED. Of all the ways to look at the narrative, this one perspective frames a story that supports all identified conditions for each case in which the person with diabetes must make decisions. Ownership was acknowledged by participants’ accounts of always being mindful of diabetes, though in differing ways. “It’s always on my mind, wanting, wishing not to be a diabetic” (Participant 6, woman). “It’s a constant burden, affects every aspect of my life” (Participant 8, woman). As part of the competing standpoints, constancy of ownership (dealing with it) is defined as living with an awareness that problems might not be predicted nor always prevented but they are expected and external “. . . ‘cause you never know when it’s gonna come on you” (Participant 3, woman). Centrality of ownership is defined as acknowledging responsibility by “handling it” as part of a lived, owned identity. Handling involves taking decisions into your hands and at that moment handling them as responsibly as possible. If ownership is not acknowledged as a central focus, constancy of disease processes results in the need for “dealing with” a difficult situation.

Context of ownership—The context of perceived urgency of symptoms includes all the reasons that precipitated the most recent ED visit. Perceived urgency was felt when participants experienced slurred speech, vision loss, high or low blood sugar, or unfamiliar symptoms. Some participants admitted their neglect precipitated the emergency. Other symptoms were urgent but not life threatening, such as complications from dialysis, asthma, and vision loss. Some symptoms were vague, such as shaking, dizziness, or an unusual feeling. These were distressing because they were new or recurring symptoms not responding to usual care. A few participants were told by health care providers to go to the ED if their “sugar” was high or low, but they were not given any parameters for determining high or low. Patients on dialysis did not have definitive symptoms but they knew “something was wrong.”

Conditions of ownership—Personal experience, primary care access and services, and social network support for decisions were designated conditions influencing ownership. Conditions are salient dimensions that facilitate, block, or shape action or interaction⁹ (Kools, et al, 1996). These conditions included the personal experience of living with diabetes, access to health care services in the community, and the support patients received

from people in their home, social network, and community in making the decision to use the ED. From the participants' perspectives, reasons for going to the ED focused solely on their symptoms: hypoglycemia, dizziness, stroke symptoms, dehydration, ketoacidosis, abscesses, wound complications, vision problems, respiratory problems, cardiac symptoms, gastrointestinal problems, and loss of consciousness. Personal experience influenced knowing and doing.

Personal experiences of knowing included cognitive processing of symptoms: knowing what to do, knowing what was wrong, knowing signs of problems, knowing your body, knowing yourself, knowing by listening to your body, and not knowing anything. Another dimension of personal experience was learning how to manage diabetes: how to eat, how to cheat, how to do the right things, and learning the hard way. Personal experience also included beliefs and feelings. One participant believed that everyone had some amount of diabetes, some worse than others. Emotional processing included feelings of anger, fear, frustration, regret, worry, unhappiness; feelings that were up and down "like a rollercoaster." (Participant 2, woman). Some said, "It's hard, it's so very hard" (Participant 1, man) expressing emotions of depression, burden, and resignation.

Behavior or doing what they knew to do was another dimension of personal experience and included habits, routines, asking for information, and watching for signs. Neglectful behaviors were admitted. Participants sometimes neglected to eat as they should. They neglected to take their medicine, or to get prescriptions refilled. They did not check their blood sugars or buy their monitoring supplies. Some missed scheduled medical appointments. Routines were also significant dimensions of the experience as they tried to do what they normally did, such as attend church and take the children to school, despite feeling something was wrong.

Primary care access and services included transportation barriers. Some were unable to get medications refilled because they could not get to their appointment to obtain a prescription renewal and the physician would not approve a refill without a primary care visit. Affordability of the doctor visit, prescriptions, lancets, monitoring strips, even orange juice for hypoglycemia were all recurring issues. Lack of insurance or co-payment affected ability to get medicine in a timely way. Some who had access, however, chose not to take their medication. "I the one made the decision; I the one that decided to stop taking the medicine." (Participant 1, man).

Acceptability, an access factor, included attitudes toward providers who did not answer questions or explain problems. Thoroughness at the visit was important to participants who noted whether their vital signs were taken, labs were done, and feet examined. Some participants disliked hospitals, saying, "I was treated like cattle, with disrespect and no regard for protecting privacy" (Participant 19, man). Others disliked going to the doctor's office because of long waits or seeing a different doctor each time.

Support in making the decision to go to the ED was provided by friends and relatives who accompanied participants. One woman had symptoms of blurred vision and urinary frequency. When she almost passed out, her husband insisted that he take her to the ED. The

wife of another participant strongly urged him to go because of swelling around his recent amputation. Family members and coworkers provided strong encouragement in two instances of impending “stroke symptoms.” Examples of nonfamily support included a nurse and a doctor. In one case the usual physician instructed the patient to go to the ED because no appointment time was available. In another case a police officer accompanied one participant to the ED after she was stopped for unsafe driving. The importance of support was captured by Participant 1 (man) who said “if you ain't got the understanding of what to do for yourself, and you ain't got nobody to tell you, who can just guide you along the way and tell you must do this, then diabetes will knock you off your feet quick.”

Processes of ownership—Processes were either central or constant. When the overarching perspective of ownership was central, the participant was “handling it.” When the perspective was constant, the participant was “dealing with it.” Handling it involved management through adherence to diet, medication, exercise, and weight control. Knowing what to do was a dimension of personal experience (condition) and influenced, but did not determine, the action taken. Doing “what you got to do” was not always “doing what you know to do.” The perspective of ownership for each standpoint could vacillate or be contested between managing well and not managing well because each participant made an ambulatory sensitive ED visit. Those who internalized ownership as central at the time admitted their responsibility to handle their disease better to avoid future emergencies. Those who externalized their ownership denied responsibility and dealt with the experience by fighting back.

The dimensions of centrality of ownership were awareness, anticipation, and assurance. Being aware of symptoms by listening to your body and paying attention to the doctor's instructions fostered more vigilance. Anticipation promoted saving to pay for needed medication, to have candy available for low blood sugar, to drink enough water, and to anticipate insulin needs for carbohydrate intake. Assurance was demonstrated as keeping things under control. Comments of centrality of ownership included: “Listen to yourself, there's always a voice inside of you” (Participant 9, man). “I have to live with it and I'm willing to control it” (Participant 9, man). Ownership was expressed by one who said, “This is the number 1 killer for Black Americans and I'm one of them that's listed in there and I don't want to see my name on that list (Participant 9, man). Owning, rather than being owned by diabetes, suggested responsibility to “pay attention to this thing,” and “live productive and take your medicine” (Participant 6, woman).

Dimensions of ownership as constancy included blame, dependence, resignation and struggle. Resignation was expressed as being stuck with diabetes. Ownership sometimes included taking responsibility for neglect. “I know I caused the problem by not doing the stuff I needed to do” (Participant 4, man). Constancy of ownership was expressed as blaming self or others for the disease or the ability to self-manage. A participant blamed providers for not notifying her of an abnormal lab value: “They should'a let me know, I would'na have to go on that needle” (Participant 5, woman). Another blamed friends: “. . . 'cause some of your friends bring on the problems and they bring the same problem back to you, your drinking friends” (Participant 4, man). Being owned by the illness was expressed as trying to beat it. The fight analogy was suggested by participants' comments such as, “I don't wanna

die, not this way if I can beat the complications” (Participant 1, man). Many participants used words about fighting and conflict to describe dealing with their illness.

Consequences of ownership—Processes of ownership lead to the consequences of either handling or dealing with the disease to be a regular person. A participant who was blind said, “I don’t let it slow me down. I still do my normal activity” (Participant 18, man). Others had difficulty completing old routines, saying, “It is extremely life altering” (Participant 19, man). One person described life with disease as sometimes normal: “I don’t have it sometime ‘cause you just . . . same regular person. (Participant 18, man). One participant seemed to capture the idea of having disease yet being a regular person saying, “The thing is you got to stop doing is the stuff you need to stop doing anyway to keep healthy” (Participant 4, man).

Discussion

Conceptualizing the process of ED use for ambulatory sensitive issues requires understanding how participants make decisions. Ambulatory sensitive ED use occurs within the interacting dimensions of personal experience, primary care access and services, and social network and community support for decision making. According to the chronic care model¹⁷, patients are in control of choices made in the context of their personal lives. Patient self-management support includes the social network of family, friends, and the community environment of resources¹⁸. An informed, activated patient is a goal of the chronic care model and an empowered patient makes responsible decisions. The decision leading to ED use is partly a function of the illness experience, which is unique for each individual^{19,20}. To promote empowered patients, providers need to be sensitive to the illness experience as perceived by the individual. Jayne and Rankin²¹ support this strategy by noting that the main influence on management decisions was daily life experiences rather than treatment prescribed by providers.

Contested ownership of illness expressed as “doing what you got to do” is the overarching perspective for understanding how these participants made the decision to use the ED. This research supports current knowledge that ownership is a part of the self-identity of someone with a chronic illness^{21,22,23}. One of the dimensions of ownership is taking control^{22,23,24}, expressed in this study as handling it and “doing what you got to do” to be a regular person. “Handling it” included maintaining routines as much as possible. These participants wanted to experience stability, but also wanted their diet and exercise to fit into their lives to feel like a regular person.

Self-management of chronic illness is not a static process but one that vacillates with changes in identity in relation to the disease^{25,26,27}. Chronic illness brings a shift in self-identity in the quest for bringing order to life²⁶⁻²⁸. Olshansky, et al.²⁶ described persons with diabetes who accepted disease as central to their identity but who still wanted to fight it at times. Tilden, Charman, Sharples, and Fosbury²⁹ described a “diabetic identity” that might be incongruous with the patient’s self-perspective and lead to poor adherence. Rejecting that identity results in rejecting management of the disease. There was no indication that participants expressing central ownership consistently handled their illness better or made

better decisions, despite the expectation that taking control for oneself will prevent problems³⁰. Ambiguity, even self-blame, must be expected because of the sense of powerlessness in the face of the demands of an illness that never lets up^{27,30}. At the point of making a decision, ownership provides a choice, to be responsible and take control or try to fight and possibly lose the struggle without others to help. Choices that result in a crisis might not be avoided when existing health services are not accessible or responsive, as research about disparities suggest^{31,32}. Urgent symptoms require attention and decisions must be made, to “deal with it the best you can” even if it means going to the ED.

Life events and circumstances mediate management decisions in chronic illness³³. The experience of having been through problems with their illness affirmed for some participants that they could handle it again. There is a turning point, an epiphany²² at which a new realization changes things. In a crisis, active involvement might become passive³³. With a loss of power comes a loss of control and responsibility²². Not knowing or understanding what to do leads to a sense of vulnerability. This loss of personal power and loss of control increases vulnerability³⁷. A common response is to overcome this identity threat by fighting²². When a person talks of beating this disease, he might be conveying a sense of constancy, indicating the disease owns him and his identity is threatened. Self-management has been described as the need to be in charge, “working hard with it”³⁰. Rather than working with the disease, those experiencing loss of power respond to the threat by wanting to fight diabetes. Care providers who recognize the patient's ownership perspective can better provide instruction tailored to the patient's viewpoint. This is difficult when services provide poor communication or continuity of care.

Context drives the decision making process³³. Perceived urgency drove the decision to use the ED. Personal experiences, primary care access and services, and social network support for decision influenced the process of using the ED as any person would in a crisis. The support of family, friends, employers, or public servants contributes to ownership because identity is constructed in social interactions²². We found that social network support impacts decisions, good or bad. Help with decisions does not negate self-management but rather reflects the relational nature of people²⁵. Handling the illness involved regulating their life, changing some activities, and being vigilant to signs and symptoms. Yet as experiences and decision support change, so does ownership. Instead of handling the illness, one has to take the “cards he is dealt” and deal with it.

People with chronic illness might minimize their symptoms or consider them normal³³. Zoffmann and Kirkevold³⁴ explained how providers and patients prioritized disease and life concerns that resulted in conflicting processes. Imbalances result when providers suppose the problem to be one of “not having accepted the disease” and “blaming everything on her diabetes” (p. 760). These comments are similar to findings in our study describing consequences of ownership. The goal is to live a normal life by integrating diabetes but achievement cannot be realized without reaching a significant “turning point” or epiphany. This identity reconstruction toward normalcy includes viewing diabetes as central²⁶. Sometimes ownership is internalized and central, but sometimes the disease that is constantly interfering in their life owns the person. When identity is taken over by disease, loss of personal power and vulnerability are likely and the response is to fight²². When

knowledgeable support for decision-making is available within social networks or community resources, unsuccessful processes such as ambulatory care sensitive ED visits might be avoided.

Limitations of this study are many. Data for this study were interpreted rather than measured and, though not generalizable, the data are credible based on coding methods grounded in the data for the context of this group of participants. Sampling purposively included all of the patients within the context of access to a major ED in a specified time period, but did not exhaust theoretical leads suggested by the themes. Additional limitations include limited member checks to validate conclusions and particular characteristics of participants, such as gender, education, income, or length of disease that were not explored for variation in responses.

However, the data provide significant insights into factors affecting ownership and self-management of diabetes as well as the contested ownership of diabetes by participants. The importance of ongoing diabetes self-management training/education and behavioral support for the patient and their support networks cannot be over-emphasized for the participants in this study. Insight into signs, symptoms, behaviors and conditions that can be managed by the patient or their social support network versus those that need management by primary care provider, or those requiring ED management was needed by each of the participants (and some of the family members influencing patient behaviors) in this study, yet was missing overall. Special emphasis is needed for helping patients identify when to seek care from their diabetes provider versus the emergency care system providers, and changing systems to make that primary care more quickly accessible to the patient when needed. To decrease ambulatory sensitive use of the ED and control costs of health care, we must help our patients to decrease vulnerability and increase personal power over diabetes, attending more proactively to the misconceptions, emotional conflicts, missed communication about the disease, and potential variations in quality of care.

Acknowledgments

The authors disclosed receipt of the following financial support for the research of this article: National Institutes of Health National Institute of Nursing Research 1 R15 NR009486-01A

References

1. Centers for Disease Control (CDC). [September 27, 2014] National Diabetes Statistical Report, 2014. 2014. from: <http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>
2. American Diabetes Association (ADA). [March 17, 2013] Economic costs of diabetes in the U.S. Diabetes Care. published online ahead of print March 6, 2013 from <http://care.diabetesjournals.org/content/early/2013/03/05/dc12-2625.full.pdf>
3. Stern Z, Calderon-Magalit R, Mazar M, Brezis M, Tirosh A. Emergency room visit: A red-flag indicator for poor diabetes care. Diabetes Medicine. 2009; 26:1105–1111.
4. Galarraga, JE.; Pines, JM. Costs of ED episodes of care in the United States. Am J Emerg Med. 2015. <http://dx.doi.org/10.1016/j.ajem.2015.06.001>
5. DeLia, D.; Cantor, J. Emergency department utilization and capacity. 2009. (Research Synthesis Report No. 17). Retrieved from Robert Wood Johnson Foundation website: <http://www.rwjf.org/content/dam/farm/reports/reports/2009/rwjf43565>

6. South Carolina Department of Health and Environmental Control (SCDHEC). Burden of Diabetes in 2012 Report. Columbia, SC.: 2013. Retrieved from SC DHEC Office of Chronic Disease Epidemiology and Evaluation website: <http://www.scdhec.gov/administration/library/CR-010714.pdf>
7. Morganti, KG.; Bauhoff, S.; Blanchard, JC., et al. The evolving role of emergency departments in the United States. 2013. Retrieved from RAND Health website: http://www.rand.org/pubs/research_reports/RR280.html
8. Charmaz, K. Constructing grounded theory. Sage; Thousand Oaks, CA: 2006.
9. Schatzman, L. Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research.. In: Maines, D., editor. Social organization and social process: Essays in honor of Anselm Strauss. Aldine De Gruyter; NY: 1991. p. 303-314.
10. Kools S, McCarthy M, Durham R, et al. Dimensional analysis: Broadening the conception of grounded theory. Qualitative Health Research. 1996; 6:312–330.
11. McHale P, Wood S, Hughes K, et al. Who uses emergency departments inappropriately and when: A national cross-sectional study using a monitoring system. BMC Medicine. 2013; 11:258. doi: 10.1186/1741-7015-11-258. [PubMed: 24330758]
12. Honigman L, Wiler J, Rooks S, et al. National study of non-urgent emergency department visits and associated resource utilization. Western Journal of Emergency Medicine. 2013; 14:609–616. [PubMed: 24381681]
13. Charmaz K. 'Discovering' chronic illness: Using grounded theory. Social Science & Medicine. 1990; 30:1161–1172. [PubMed: 2360052]
14. Glaser, BG.; Strauss, AL. The discovery of grounded theory: Strategies for qualitative research. Aldine Publishing Company; Chicago: 1967.
15. Gomersall T, Madill A, Summers LKM. A metasynthesis of the self-management of type 2 diabetes. Qualitative Health Research. 2011; 21:853–871. [PubMed: 21429946]
16. NVivo qualitative data analysis software. Version 8. QSR International Pty Ltd; p. 2008
17. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. Milbank Quarterly. 1996; 74:511–544. [PubMed: 8941260]
18. Authors. Expanding the chronic care framework to improve diabetes management: The REACH case study. Progress in Community Health Partnerships: Research, Education, and Action. 2010; 4(1):65–79.
19. Funnell MM, Anderson RM. Empowerment and self-management of diabetes. Clinical Diabetes. 2004; 22:123–125.
20. Skelly AH, Leeman J, Carlson J, et al. Conceptual model of symptom-focused diabetes care for African-Americans. Journal of Nursing Scholarship. 2008; 40:261–267. [PubMed: 18840210]
21. Jayne RL, Rankin SH. Application of Leventhal's self-regulation model to Chinese immigrants with type 2 diabetes. Journal of Nursing Scholarship. 2001; 33:53–59. [PubMed: 11253580]
22. Karnilowicz W. Identity and psychological ownership in chronic illness and disease state. European Journal of Cancer Care. 2010; 20:276–282. [PubMed: 20738388]
23. Winkelman WJ, Leonad KJ, Rossos PG. Patient-perceived usefulness of online electronic medical records: Employing grounded theory in the development of information and communication technologies for use by patients living with chronic illness. Journal of the American Medical Informatics Association. 2005; 12:306–314. [PubMed: 15684128]
24. Koch T, Jenkin P, Kralik D. Chronic illness self-management: Locating 'self.'. Journal of Advanced Nursing. 2004; 48:484–492. [PubMed: 15533086]
25. Delmar C, Bøje T, Dylmer D, et al. Independence/dependence – a contradictory relationship? Life with a chronic illness. Scandinavian Journal of Caring Sciences. 2006; 20:261–268. [PubMed: 16922979]
26. Olshansky E, Sacco D, Fitzgerald K, et al. Living with diabetes: Normalizing the process of managing diabetes. Diabetes Educator. 2008; 34:1004–1012. [PubMed: 19075082]
27. Paterson BL. The shifting perspectives model of chronic illness. Journal of Nursing Scholarship. 2001; 33:21–26. [PubMed: 11253576]

28. Kralik D, Koch T, Price K, et al. Chronic illness self-management: Taking action to create order. *Journal of Clinical Nursing*. 2004; 13:259–267. [PubMed: 14723679]
29. Tilden B, Charman D, Sharples J, et al. Identity and adherence in a diabetes patient: Transformations in psychotherapy. *Qualitative Health Research*. 2005; 15:312–324. [PubMed: 15761102]
30. Utz SW, Steeves RH, Wenzel J, et al. “Working hard with it” self-management of type 2 diabetes by rural African Americans. *Family & Community Health*. 2006; 29:195–205. [PubMed: 16775469]
31. McKinlay J, Piccolo R, Marceau L. An additional cause of health care disparities: The variable clinical decisions of primary care doctors. *Journal of Evaluation in Clinical Practice*. 2013; 19:664–673. doi: 10.1111/jep.12015. [PubMed: 23216876]
32. Vaccaro JA, Huffman FG. Reducing health disparities: Medical advice received for minorities with diabetes. *Journal of Health and Human Resources Administration*. 2012; 34:389–417.
33. Paterson BL, Russell C, Thorne S. Critical analysis of everyday self-care decision making in chronic illness. *Journal of Advanced Nursing*. 2001; 35:335–341. [PubMed: 11489013]
34. Zoffmann V, Kirkevold M. Life versus disease in difficult diabetes care: Conflicting perspectives disempower patients and professionals in problem solving. *Qualitative Health Research*. 2005; 15:750–765. [PubMed: 15961873]

Table 1

Explanatory Matrix

Overarching Perspective: Contested Ownership

Context	Conditions	Processes	Consequences
Perceived urgency	Personal experience	Constancy: Dealing with it	Being a regular person
Consciousness	Knowing what to do	Blaming someone	
Life threatening	Learning what to do	Depending on others	
Complications	Doing what I know	Resigned	Fighting back
New symptom	Doing what I usually do	Struggling	
	Feelings about self	Centrality: Handling it	Taking control
	Primary care access/services	Awareness	
	Transportation	Adherence	
	Cost of visit	Avoidance	
	Attitudes about provider	Anticipation	
	Appointment delays	Assurance	
	Support for decision		
	Giving advice		
	Going with		
	Taking over		