When older adults are super utilizers of emergency departments

By Cathy Sendecki, BSN, RN, GNC(C)

The definition of 'super utilizers' of the emergency departments (ED), sometimes referred to as 'frequent flyers' varies, from those who visit four or more times a year (Grover, 2009), to those having 20 or more annual visits (Champion, 2015). These individuals account for less than 4% of overall ED visits (Soril, 2013), but most ED nurses soon get to know a few patients in their area who visit much more than this, some every few weeks for ongoing needs, some every few days. This can be a frustrating experience for the patient, who may disclose a perception of declining empathy although their symptoms continue. Even when the patient feels well supported during the ED visit, the lack of progress in resolving their issues can be worrisome and tiring. For staff, there can be frustration, as we are unable to resolve the chronic issues that plague this patient, or even provide significant relief. There may also be a feeling that these persons are abusing the system by coming frequently to the ED rather than seeing their GP, or waiting to see a specialist. There may also be concerns that the ambulance system is being misused to bring someone relatively stable to the ED, causing delays for more urgent cases.

The literature has identified adults who visit EDs generally suffer from at least one chronic illness (Champion, 2015). They may have issues with transportation, housing, or mental illness; and contrary to the perceptions of ED physicians and nurses, these people are often high users of other services, as well as the ED. Often, psychosocial issues and substance misuse contribute to their health care needs (Grover, 2009).

Repeatedly, studies reveal that 'super utilizers' perceive the hospital to provide superior care to that available elsewhere, such as an office visit (Champion, 2015). As care providers, we recognize that something may be seriously wrong on this visit, and when the history is not known, comprehensive examinations may expose these patients to the risk of excessive radiation and discomfort, as well as cost to the system (Grover, 2009).

Some measures to improve the outcomes for super utilizer patients and the ED have been developed. For example, in Vancouver, a program has been developed in which a case manager works with these patients to integrate crisis intervention, supportive therapy, and ongoing care, with attention to housing and other social needs (Pope, 2000). In Saskatoon, housing and other social determinants of health have been addressed to provide "upstream" support to prevent the need for ED visits (Meili, 2013). In other areas, individual care plans have been developed as interdisciplinary health care providers and the patient work together to identify needs and interventions. Little information is available to identify if these approaches result in fewer ED visits, but more consistent care is provided.

The situation for older adults who frequent EDs is often complicated by changes of aging. Issues of mobility and transportation, housing, poor nutrition, and increasing burden of chronic illness may become more prevalent with age. In some instances, cognitive decline plays a significant role. It is difficult to ascertain why someone has come when the patient can describe only vague complaints of uncertain duration. Often, our instructions to follow up with a family physician do not result in a decrease in ED visits.

As a Geriatric Emergency Nurse Clinician, I am consulted when seniors are perceived to be visiting our ED frequently. This may be on the second or third visit in as many days, or it may be for someone who has been coming monthly for years and today that person is here during my shift. As with so many scenarios involving seniors, the range of presentations is broad. Early in my career, one elderly man who lived alone near the hospital came to the cafeteria for dinner several nights a week. Then he began to stop by the ED at times. He was vague as to how he was managing at home, and didn't want to bother his niece, his only local family. My mentor at that time stated such patients often "know something is wrong", and therefore make contact with the ED. In the case of this gentleman, when he gave us permission to contact his niece, she was eager to help, and arranged adequate food and support.

For many, there is not such a positive outcome. Some of these patients have evidence of cognitive impairment, but they are able to manage with some support in the community, and often remember how to call an ambulance. This may go on for months or even years, and can be frustrating for paramedics, who are called frequently, and the ED staff. The cycle tends to end when a crisis occurs, requiring admission to hospital or their cognitive impairment worsens and arrangements are made for ongoing care.

The occurrence of mental health conditions, as well as physical illness affecting many of these patients can complicate their management. In my experience, the mental health concerns are not generally so acute as to warrant an emergency referral to psychiatry, but outpatient referrals may be forgotten or rejected. Even when some of these patients have been seen by psychiatry, they eschew ongoing care.

Despite these barriers to care, these people come to us. What can we realistically offer?

- As always, accurate assessment: Why is this person coming so often? Are these visits for management of pain following compression fractures? When the patient can give only vague information, seek collateral information from family or friends. Identify who can investigate further: social work or home health may be able to identify needs and interventions. Involve the patient's family physician if there is one, so the ED and other healthcare providers are giving consistent care.
- Intervene as appropriate: Considering history to avoid unnecessary duplication of examinations, but with consideration for complexity of needs.
- Make a concise history and care plan readily available so physicians and staff have necessary information for each visit: For example, one patient with COPD has been given Prednisone and, at times, Lorazepam; both caused delirium. Now that this information is available on every visit, she has had a more stable course.
- Provide printed instructions on discharge, in a font large enough for this patient to read.
- Consider the possibility of a history of trauma: Defined as "experiences that overwhelm an individual's capacity to cope." This may occur at any time, from early life to a later time, and may be a single incident or an ongoing situation. Trauma is common, as 76% of Canadian adults report some form of trauma exposure in their lifetime (B.C. Centre of Excellence for Women's Health, 2013). While most people are resilient, and develop healthy ways of coping, illness, exhaustion or overwhelming events at a later time may cause a recurrence of an earlier response.

While an in-depth discussion of trauma informed practice is beyond the scope of this article, there are aspects of this approach that may benefit these patients and can be incorporated into the practice of emergency nurses. Trauma-informed practice is addressed most frequently in the setting of mental health practice, but we, in the emergency care community, need to consider how we can incorporate the principles into our practice. For example, a trauma-informed approach places "priority on the individual's safety, choice, and control" (B.C. Centre of Excellence for Women's Health, 2013).

Four aspects to consider are:

1. Trauma awareness: increased knowledge about the prevalence and effects this may have on our patients, as well as on us.
2. Safety and trustworthiness: provide consistent care, clear information about the options for care, ensure informed consent. For example, refer to home health only if the patient agrees.
3. Provide opportunities for choice: this may be limited during the ED visit but, where possible, this gives the patient some control of their situation, for example, give information about how to contact home health if they need to change the time of the appointment.
4. Assist patients to identify and build on their strengths. This approach can also enable us to gain a better understanding of what this person is dealing with.

As an illustration

Mrs. P. is an 88-year-old widow, living alone in an apartment. In the past, she had accompanied her husband on his hospital admissions, but since his death a few months ago, she has had several ED visits. She has frequently experienced chest pain, and has come to hospital by ambulance. The paramedics sometimes report concerns about medication management, noting tablets spilled on the floor. On each visit, investigations reveal no cardiac cause for her symptoms and she is discharged. She is instructed to see her family physician, but returns to the ED before making an appointment. She is offered a home health referral, but declines, as she has fallen behind in her housework and doesn't want "strangers to see my home like this."

On one visit, the emergency physician and nurse speak with her to discuss that despite several visits, her health continues to be a concern, explaining that while no acute illness is present, she requires ongoing support. Her care for her late husband is acknowledged and she is encouraged to accept help now for herself. A home nursing visit is recommended, and the Quick Response Case Manager comes to the ED to speak with her before discharge, gaining her consent for a home visit. An appointment with her physician is also made before she is discharged. Printed instructions are reviewed with her before she goes home. These measures are outlined in a care plan, which is flagged on subsequent visits.

Over the next several weeks, Mrs. P. makes a few more visits to the ED. She is again reassured, and the importance of ongoing follow-up is emphasized. When she comes to the ED again near the anniversary of her husband's death, the staff realize she had not come for some time and acknowledge that she has done well with their support.

As a final note, we need to accept that, as ED practitioners, we may experience frustration when caring for 'super utilizers.' Sometimes we can identify definitive strategies to provide relief for the presenting symptoms, but there are times we will not achieve this. We can feel professional satisfaction in knowing we have done a thorough assessment and addressed relevant issues. We may need to refer to other disciplines, and we may continue to see this patient often. We may be the safety net for these vulnerable patients, ensuring they have the best possible care while they struggle with complex needs.

About the author

Cathy Sendecki, BSN, RN, GNC(C), has worked at Burnaby Hospital Emergency Department since 1987, in the past several years as Geriatric Emergency Nurse Clinician, as part of the Older Adult Program. Particular interests include working with persons with dementia and their care partners and embracing the challenges of dealing effectively with Elder Abuse. She enjoys being a grandma.

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Tidbits & Trivia Fall 2016

Submitted by Janice L. Spivey

- The American Association of Retired Persons (AARP) June/July 2016 magazine reported that older feet are less sensitive to heat, so our "senior" patients may not realize how hot the beach sand is until it has already done its damage, which could include second and third degree burns, according to Shriners' Hospitals' David Greenhalgh, MD. The risk of injury is greater for diabetics or vasculopaths, who have decreased sensation in their feet. Surf shoes or sandals are recommended and cool (not cold) soaks for red feet, with medical care for blister formation.

  Supported by:
  Wickremaratchi, M.M., & Llewelyn, J.G. (2006). Effects of ageing on touch. *Postgrad Med J*. 2006 May; 82(967), 301–304. doi:10.1136/pgmj.2005.039651

- The Stanford University School of Medicine recommends that to cool down after a workout, we should try chilling our hands. Cooling the palms has been found to help to circulate blood and pull heat from the body.

  Supported by:
  Berkeley Wellness. October 1, 2012. *"Cool Hands."* Retrieved from http://www.berkeleywellness.com/fitness/exercise/article/cool-hands

- Researchers at the University of Auckland, New Zealand have found that honey reduces healing time significantly when applied to wounds because of its antibacterial and anti-inflammatory properties.

  Supported by:
  Jull, A.B., Rodgers, A., & Walker, N. (2009). Honey as a topical treatment for wounds (Review). *The Cochrane Library 2009*, Issue 4. Retrieved from https://researchspace.auckland.ac.nz/bitstream/handle/2292/7841/cd005083.pdf?sequence=3

- Did you know that according to the Canadian Association of Retired Persons (CARP), the first recorded use of Cannabis as medicine was in China in 2737 BC? It was recommended to treat gout, rheumatism, malaria and constipation.

  Supported by:
  Rose, S.D. (2013). *Traditional Chinese medicine: How marijuana has been used for centuries.* Northwest Leaf: the patient's voice. Retrieved from http://www.thenorthwestleaf.com/pages/articles/post/traditional-chinese-medicine-how-marijuana-has-been-used-for-centuries
  Abel, E.L. (1980). *Marijuana,* The First Twelve Thousand Years. New York: Plenum Press