Deciding to Use the Emergency Room: A Qualitative Survey of Older Veterans

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Deciding to Use the Emergency Room: A Qualitative Survey of Older Veterans

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Increasing use in the past decade has created pressure for hospital emergency rooms (ERs). Healthcare provided through an ER is expensive and is not designed to meet the complex needs of an older, chronically-ill population. ER visits are presented as the outcome of a decision-making process. Thirty veterans who had visited the ER in the previous year were asked about their decisions to use the ER. Their responses reflected four distinct approaches to ER use, which are characterized by frequency (frequent/infrequent) and risk for social isolation (low/high). Appropriate interventions by social work personnel might reduce inappropriate use of the ER and enhance the care of this vulnerable population.

KEYWORDS emergency room, veterans, case studies, decision-making

Mr. Davis, an 82-year-old World War II veteran, arrived at the Veteran Affairs (VA) Medical Center emergency room (ER) on a Wednesday night because he ran out of medications. He was released 4 hours later with a refilled prescription. ER staff discovered that this was Mr. Davis’s fourth visit to the ER in the past year. Why do some older veterans (aged 65 or older) frequently use the ER, which is the most expensive form of care, and is not designed to address the complex needs of an older, chronically-ill population? Frequent ER use is especially perplexing when there is not a medical emergency and indicates a mismatch between need and service because there are services at

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the VA that could better meet these nonemergencies. Inappropriate or excessive use of emergency rooms has been identified as a significant problem for the US health care system. Costs are a significant consideration. Baker and Baker (1994) found that care provided in the ER costs two to three times more than care provided in other settings. Moreover, ER care is not designed to meet the complex needs of an older, chronically-ill population (Andren & Rosenqvist, 1987; Damron-Rodriguez, Wallace, & Kington, 1994).

A visit to the ER represents the outcome of a patient’s decision-making process initiated by the recognition of a symptom (Stage I), appraisal of that symptom as serious enough to require medical attention (Stage II), and a decision that the ER is the most appropriate avenue for obtaining that care (Stage III; Padgett & Brodsky, 1992). By intervening in this process, social workers can both reduce inappropriate ER use and enhance the quality of care for older adults. This will require understanding the decision process itself, specifically the factors that predict ER use.

PREDICTING ER USE

Social Support Networks and Illness Burden

Factors associated with ER use include demographic characteristics (McCusker, Healey, Bellavance, & Connolly, 1997; Padgett, Struening, Andrews & Pittman, 1995); resources such as income and insurance available (Shah, Rathouz, & Chin, 2001); and subjective and objective judgments about the user’s physical, mental, and emotional health (McCusker, Cardin, Bellavance, & Belzile, 2000; Shah et al., 2001; Sun, Burstin, & Brennan, 2003). Social support may make an additional contribution to ER use, but its exact role in the decision-making process to visit the ER is not clearly understood.

Claver and Levy-Storms (2010) expanded the Padgett and Brodsky (1992) model to include the roles of social support and illness burden on older veterans’ decision making to visit the ER. They found that: (a) Frequent ER users visit the ER for acute co-morbidities related to chronic illness symptoms but infrequent ER users visit the ER for accidents and injuries; (b) frequent ER users tend to go through more elaborate decision-making than do infrequent ER users about when to use the ER, attempting wait-and-see and self-care behaviors to avoid or postpone an ER visit; (c) those at high risk for social isolation tend not to have help recognizing symptoms; however, even socially isolated veterans have at least one social support network member they can ask for assistance (although many veterans prefer to make decisions about ER use without help, regardless of the social support network available); (d) formal support members (i.e., paid caregivers and VA providers) are a significant source of support in decisions to visit the ER. Those with formal caregivers are less likely than those without formal
caregivers to recognize their own symptoms; and (e) social support networks provide linking support in decision-making to get medical attention for a problem, as evidenced in veteran reports that spouses, family members, and friends, when consulted, almost unanimously suggest visiting the VA and/or ER for a problem. This is particularly true for those with low risk of social isolation and for those with high illness burden, who postpone visits to their providers.

To bridge theory and practice, this article provides research-based case studies of frequent and infrequent ER users who have varying levels of social support and illness burden. The aim of the case studies is to provide health care providers concrete examples they can use to identify veterans who may be at risk for frequent ER use. Early identification of these veterans would allow providers to offer intervention with appropriate care that could reduce emergency room use.

**METHOD**

The study’s objectives were to understand: (a) the process by which veteran ER users decide to visit the ER, and (b) the role of social support networks in the decision-making process. To describe a range of possible decision-making approaches, male veterans aged 65 and older whose ER use was either low or high and whose risk of social isolation was low or high were targeted in recruitment activities. Potential participants were recruited by VA providers and signed consent forms before being interviewed. Face-to-face interviews took place at the VA in a private room or at the participants’ home (in two cases) and lasted approximately 30 min each (with the exception of one, which was conducted by telephone with a veteran who was at home). Veterans were asked to report on their ER use, social support networks, and demographics. The research was approved by the institutional review boards of the University of California, Los Angeles and Veterans Affairs Greater Los Angeles Healthcare System.

**Measures**

**Frequency of ER use.** Respondents were asked how often they had visited an ER in the prior 12 months. Although past research has shown that self-reported use of the ER, in particular, tends to be inflated when compared with chart reviews (Ritter et al., 2001), veteran self-reports of use were accepted for the purposes of this study.

The research definition of frequent emergency room use has ranged from as few as three to as many as 20 visits per year (Malone, 1995; Sun et al., 2003). The most commonly-used frequency by which researchers have defined chronic ER use has been four to six visits in the past 12–15 months.
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(Andren & Rosenqvist, 1985, 1987; Malone, 1995; McCusker et al., 2000; Purdie, Honigman, & Rosen, 1981). For the purposes of this study, frequent use was established at three or more visits per year to make meaningful comparisons between groups. Although frequent users (3 or more visits per year) were the primary focus of this study, low-frequency users (1–2 visits per year) were also recruited to provide data for greater depth to this inquiry.

Social isolation risk. The Lubben Social Network Scale, or LSNS, (Lubben, 1988) assessed each participant’s risk of social isolation and has a reliability coefficient of 0.84. Scores on this scale can range from 0 to 50, and lower scores indicate a higher risk of isolation. Scores are often interpreted as belonging to one of four categories: isolated (≤20), high risk isolation (21–25), moderate risk isolation (26–30), and low risk isolation (>30). However, for this study, the categories were collapsed into two levels, high risk for isolation (0–20) and low risk for isolation (21–50) to create two comparative groups.

To supplement information gained through the LSNS and get a better understanding of the veteran’s decision-making process to go to the emergency room, the veteran was asked if he was alone when the emergency occurred and, if not, who was with him. If the veteran was with someone, he was asked if and how that person was able to help him during the emergency. If the veteran was not accompanied by another person during the emergency, he was asked if he was able to speak to anyone over the telephone before going to the ER to explore the type of information or advice another person gave to the veteran during the emergency and how that person helped the veteran make the decision to go to the ER.

Illness burden. A chart review using a modified Cumulative Illness Rating Scale or CIRS (Miller & Towers, 1991; Parmalee, Thuras, Katz, & Lawton, 1995) guided an assessment of the severity of each veteran’s health problems. A VA physician completed the CIRS chart reviews without knowing the level of ER use for each veteran (e.g., low or high ER use). The CIRS has been validated with institutionalized older populations as an instrument that can indicate health status and predict long-term outcomes for older residential populations (Parmalee et al., 1995). It has also been validated for use with older patients in other settings (Hudon, Fortin, & Vanasse, 2005) and with various co-morbid conditions (de Groot, Beckerman, Lankhorst, & Bouter, 2003; Mistry et al., 2004). Its reliability coefficient with an outpatient population is 0.78 (Miller et al., 1992).

The CIRS evaluates 14 body systems (e.g., heart, vascular, respiratory, upper GI, lower GI) on a five-point scale ranging from zero to four (Miller & Towers, 1991). Although the scoring method can yield five separate scores, this study used the total score (maximum 56) and the number of categories at level three or four (severe to extremely severe) to characterize the illness burden for this group of veterans. For the purpose of this study, participants were categorized as having either low or high illness burden.
Data analysis and case study construction. Data analysis employed qualitative methods including interview transcription, open coding, code categorizing into themes through a comparative process, and data driven theory development (Denzin & Lincoln, 2000; Miles & Huberman, 1994). For this study, the principal investigator (PI) reviewed 30 interview transcripts to extract descriptions of how decisions were made about ER visits and the role of social support. Then, the data were displayed in a matrix, organized by ER visit frequency (high or low) and risk of social isolation (high or low). Each cell was analyzed for patterns regarding illness burden on decision making to use the ER.

Each resulting case study is a group of the veteran participants based on the study’s focal relationship of ER use and social support networks, using common characteristics of the participants in each group. Thus, four groups were identified: (a) frequent ER users at low risk for social isolation; (b) frequent ER users at high risk for social isolation; (c) infrequent ER users at low risk for social isolation; and (d) infrequent ER users at high risk for social isolation. Case studies reported here are composites of the veterans who qualified for that group and are not characterizations of any one individual. Illness burden is discussed in a case study summary for each group.

Credibility. Strauss and Corbin (1990) identified three elements required to establish credibility, which the PI has followed. First, she engaged in systematic methods of data collection and analysis, as described earlier. Second, the PI established credibility as a researcher by gaining further training and experience in qualitative research methods through participation in an on-going qualitative research group throughout the study. Additionally, she obtained individual mentorship from an expert in the area of qualitative research methods and an expert in the issues of older veterans who use the VA system. Last, to support principles of qualitative analysis such as naturalistic inquiry and inductive analysis, the PI recorded careful memos and research notes that provide an audit trail whereby future researchers can review data collection and analysis methods for researcher bias.

RESULTS

The study results will present a description of the sample, including participant demographics, frequency of ER use, social isolation risk, and illness burden. Four case studies that offer composites based on study participants who met each group profile will each be followed by a summary of the findings related to that profile.

Description of Sample

The mean age for the total study population \((n = 30)\) was 79.3 years and the range in age was from 56 to 92 years \((SD = 8.2)\). Although the study
eligibility requirements placed the minimum age at 65 years, one participant was accepted into the study due to the complications of his medical problems. Occasionally, patients with geriatric syndrome, or the medical complexity often seen in an older patient, will be accepted as a patient in the VA GRECC, as was this veteran. Thus, he was deemed eligible and appropriate for inclusion. The mean age of the study population without this patient is 80.1 years. The average number of self-reported ER visits in the 12 months prior to this study was 3.13, with a range from 1 to 12 visits. Veterans who visited the ER 1 to 2 times in the prior 12 months (n = 18) were categorized as infrequent ER users and those who visited 3 or more times in the prior 12 months (n = 12) were categorized as frequent ER users.

Participant scores on the LSNS ranged from 6 to 36 total points, and the average score was 21.5 points (SD = 8.28). The average score indicates that, as a whole, the study sample had a high risk for social isolation. Indeed, over one-third (37%) of the participants (n = 11) scored below 20 points on the scale, indicating that they were isolated. An additional nine veterans (30%) scored between 21 and 25 points on the LSNS, indicating that they were at high risk for isolation. The group of veterans with the highest risk for isolation was oldest, with an average age of 83.7 years; the group least at risk for isolation was youngest, with an average age of 74 years. Statistical analysis using the Chi-square test confirms that there are significant differences in LSNS scores based on age (p < 0.05, Fisher’s exact test).

CIRS scores for the sample ranged from 5 to 23 with an average of 13.4 (SD = 4.52). The 75th percentile score is often used to distinguish high from low CIRS scores (S. Castle, personal communication, April 4, 2006). The 75th percentile score was 17, and eight veterans scored above this. Higher scores indicate a greater illness burden. Six of the eight veterans with high CIRS scores (in the 75th percentile), or high illness burden, were also frequent ER users. All of the veterans with high illness burden also had at least two conditions that were categorized as severe. Three of the veterans with high illness burden had low LSNS scores, indicating social isolation, and the remaining five had high LSNS scores. Table 1 summarizes sample characteristics for each of the groups represented in the following case studies.

Frequent Use–Low Isolation

Mr. O’Malley is a 78-year-old Caucasian man who has lived alone for the past 10 years, since the death of his wife. He lives in a multiunit apartment building in a lower-income urban area within a 20-min drive to the VA facility. He has lived in this apartment for 10 years and knows his neighbors fairly well. One or two neighbors check in on Mr. O’Malley every day, and he feels confident that if he ever had an emergency, he could knock on a neighbor’s door and get assistance.
<table>
<thead>
<tr>
<th>Low social isolation</th>
<th>High ER use</th>
<th>Low social isolation</th>
<th>High ER use</th>
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<tbody>
<tr>
<td>$N = 6$</td>
<td>$N = 5$</td>
<td>mean ER visits – 1.5</td>
<td>mean ER visits – 5</td>
</tr>
<tr>
<td>mean LSNS score – 13.7</td>
<td>mean LSNS score – 12</td>
<td># high CIRS – 1</td>
<td># high CIRS – 2</td>
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<tr>
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<td>$N = 7$</td>
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<td>mean ER visits – 6.4</td>
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<tr>
<td>mean LSNS score – 28.4</td>
<td>mean LSNS score – 25.1</td>
<td># high CIRS – 1</td>
<td># high CIRS – 4</td>
</tr>
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*Note.* ER = emergency room. LSNS = Lubben Social Network Scale. CIRS = Cumulative Illness Rating Scale.

Mr. O’Malley estimates that he visits the VA for scheduled appointments more than 30 times a year. He uses a variety of specialty services at the VA, including cardiology, audiology, prostate, and gastrointestinal clinics. His care is assigned to the VA’s Geriatric Research, Education and Clinical Center (GRECC). His enrollment in GRECC means that he has a consistent care provider and relatively reliable access to his health care providers. He states that he feels very comfortable with his providers and would not hesitate to contact them by telephone for medical reasons, and, indeed, has done so several times in the past year.

Mr. O’Malley has had congestive heart failure (CHF) for over 15 years. CHF is a weakening of the heart’s ability to pump blood through the body and can result in the loss of normal kidney, lung, liver, and intestinal function (MedicineNet Inc., n.d.). With advancing age, it has become more and more difficult to manage his chronic health condition and he has had an increase of exacerbation of symptoms related to CHF, including swelling of the extremities and congestion in his chest, which makes it difficult for him to breathe. When Mr. O’Malley realizes that he is experiencing these symptoms, which may indicate a serious health problem, he usually tries to care for the symptoms himself, using tools and resources given to him by his providers. For example, he wears thick, tight stockings designed to reduce swelling in his legs and control fluid retention. He may or may not mention these symptoms to one of his neighbors and rarely asks for or receives advice from his neighbors about the presence of symptoms. Mr. O’Malley usually waits a day or two to see if his self-care efforts have been successful in reducing the symptoms. Sometimes they will. More often, they will not. At this point, he must decide if he will seek medical care for his symptoms.

Although Mr. O’Malley feels comfortable talking with his neighbors about health issues when he needs assistance, such as transportation to the VA, he does not seek their advice about obtaining medical care; instead, he either makes the decision on his own or calls his VA provider to get medical advice. More often than not, Mr. O’Malley visits the VA for symptoms of...
swelling and chest congestion at the recommendation of his provider. At this point, Mr. O’Malley calls one of his neighbors to drive him to the ER, which he has visited five times in the past year for symptoms related to CHF.

Qualitative data analysis did not find any clear patterns based on low or high illness burden for this group of veterans regarding Stage I: Problem Recognition. Veteran approaches to problem recognition ranged widely, from independent recognition of the problem to receiving assistance with problem recognition, or recognizing a health problem only after evaluation from a VA provider. Specifically, the veterans in this group were most likely to recognize a health problem independently, although some had help from a spouse in recognizing symptoms or did not recognize their own symptoms at all. No data from the veteran interviews in this study qualified for inclusion in the low illness burden category for Stage II: Decision to Seek Medical Care. However, data from those with high illness burden show an attempt at self-care before deciding to seek medical care. It could be that those with low illness burden did not discuss as many details about how they decided to seek medical care, or that Stage II and Stage III overlapped for this group.

Differences emerged between veterans with high illness burden and veterans with low illness burden in Stage III: Decision to Seek Medical Care in the ER. Typically, those with low illness burden made the decision to visit the ER independently, but those with high illness burden either had assistance making the decision or felt that they had no choice in the decision (someone else told them to go).

As seen in Mr. O’Malley’s case, veterans who used the ER frequently in the past 12 months and who were at low risk for social isolation tended to have one or more acute symptoms related to chronic illnesses. Although these veterans were able to identify several social support network members who could assist them in an emergency, they preferred to make these decisions independently. Assistance was usually instrumental, such as a ride to the VA. Veterans in this group underwent a complex decision-making process in which an ER visit was not the preferred method of dealing with the problem, at least not without attempting other solutions such as self-care or waiting to see what would happen. Although symptoms were considered in deciding to use the ER, so were other factors, such as knowledge about the course of their chronic illness and acute flare-ups, past experience with the ER, and feelings about what the ER could do for them.

Frequent Use–Isolated

Mr. Diaz is an 82-year-old Hispanic veteran who has lived alone for 21 years in various apartments in an urban area within a five-mile radius of the VA. Most of his friends and family members have died. However, he has been dating a woman for over 10 years who lives about an hour away
by car. They speak by telephone at least twice a day and visit each other approximately every 2 weeks. She cannot move closer to Mr. Diaz because of family caregiving responsibilities. His girlfriend is the only person Mr. Diaz can count on for support or assistance, as his chronic illnesses have isolated him from making new friends or participating in activities outside of his home.

Mr. Diaz visits the VA approximately twice a month for scheduled appointments with either his GRECC primary care provider or a specialty provider. He has cancer and low blood pressure and experiences frequent severe pain. He has endured numerous surgeries at the VA for cancer; recently his physicians have told him that the condition is terminal and that surgeries, radiation, and chemotherapy will no longer help. When he begins to experience dizziness or pain associated with one of his chronic illnesses, he attempts self-care by changing his sitting or sleeping position or by taking pain pills. Sometimes these measures ease the discomfort, but most often they do not eliminate the pain long-term. By the time he calls his girlfriend to tell her about his condition, he is very uncomfortable.

Mr. Diaz’s girlfriend, upon hearing of his symptoms, usually takes over decision-making and insists he go to the emergency room for care. Thus, once Mr. Diaz decides to involve his girlfriend, he also gives up his role in making a decision about what to do regarding his symptoms. He and his girlfriend rarely contact Mr. Diaz’s providers, preferring to go directly to the emergency room. Whenever possible, his girlfriend accompanies Mr. Diaz to the ER. Otherwise, he calls a taxi cab. He has visited the ER four times in the last year. Three visits were because of severe pain and one was due to dizziness.

Veterans in this group handled symptoms of a possible health problem and an emergency situation similarly, regardless of their level of illness burden. For problem recognition, although one example came from a veteran categorized as having a low illness burden (who suffered from anxiety), both categories of veterans have dealt with their chronic conditions for quite some time. Veterans in both the low and high illness burden categories frequently used wait-and-see techniques to postpone seeking any type of medical care (Stage II) and reported that a decision to visit the ER (Stage III) was made independently, unless a decision was made to bring another person into the situation. In cases where another person is included in the decision-making process, many of the veterans said they gave up decision-making control (usually because they were worn out from the discomfort of the health problem). Those that did not include another person in the decision-making process first tried self-care efforts. If these efforts were not successful, they decided to go to the ER. At times, a veteran would see if he could wait until his next scheduled appointment and then visited the ER if he was feeling too ill to wait. This example demonstrates the complex decision-making often experienced by frequent ER users.
Veterans who were frequent ER users and at high risk for social isolation (frequent use–isolated) had chronic co-morbid conditions. Although at high risk for social isolation according to the LSNS, they were able to identify one person who could consistently help them in an emergency. However, they were not likely to have a back-up in the case that the one social support network member was not available. The decision-making process, especially in Stages I and II, was as elaborate as in the frequent use–low isolation group, but more of the veterans in this group released decision-making to the social support network member once they decided to include and inform them that a problem existed.

Infrequent Use–Low Isolation

Mr. Horn is a 78-year-old Jewish veteran who has been married to his second wife for 13 years. He and his wife live in a home in a middle-class suburban neighborhood within a 30-min drive to the VA. Mr. Horn completed a college degree when he was 22 years old and retired from a career in accounting when he was 70 years old. He is in weekly contact with his three adult children by telephone, because all live out of state.

Mr. Horn has attended a weekly men’s support group led by a social worker at the VA for the past 2 years. He joined the group after surviving prostate cancer. He had prostate surgery 2-1/2 years ago and must take medication indefinitely. Other than his bout with cancer, Mr. Horn has occasional high blood pressure, which he manages with medication. He visits the VA approximately four times a year for appointments with his primary care provider through GRECC or with a specialist (e.g., prostate, cardiology), not counting his weekly visits for support group participation.

Mr. Horn visited the emergency room once in the last 12 months because he had an adverse reaction to a sulfa medication. He was at home watching television on a Saturday afternoon with his wife when he noticed that he wasn’t feeling “quite right.” He did not notice a rash or other visible sign of a reaction, but knew the strange feelings he was experiencing began soon after he took the new medication. He says he would have called his primary care physician to seek medical advice if it had been a weekday, but that his physician would not be reachable by phone on a weekend.

Mr. Horn immediately spoke to his wife about his symptoms and she agreed that he should not wait until Monday, but instead should visit the ER for his reaction. Mr. Horn did not ask his wife to accompany him to the ER because he felt that the situation could be handled without bothering her to sit and wait at the ER. He did not attempt any self-care or wait to see if the reaction would diminish because he wasn’t sure what one could do in this situation. Instead, he drove himself to the emergency room.

There were no major differences between veterans in this group with low and high illness burden for problem recognition. Both groups reported
having assistance in making a decision as to whether or not the symptom might indicate a problem. However, those with low illness burden experienced more unexpected and never-before experienced symptoms resulting from an accident or atypical situation. Situations leading one to seek medical care varied for this group. One veteran attempted self-care for his diabetes symptoms and the other participated in a very brief decision-making process to reach the conclusion that he should get medical care, and ultimately ER care, for injuries sustained in an automobile accident. Veterans with low and high illness burden had a diminished role in decision-making to visit the ER once someone else was involved. Thus, there were no differences between groups in Stage III. This group of veterans often involved providers in decision-making.

Veterans characterized by the infrequent use–low isolation group, who were infrequent ER users and at low risk for social isolation, were more likely to be married and share decision-making with their spouses. They were also likely to consult with a provider prior to going to the VA for care if they consulted with anyone other than a partner. Their chronic illnesses seemed to be well-managed and ER visits were due to accidents and unexpected injuries. The decision-making process to get medical care and to go to the ER for the care was less elaborate with much less wait-and-see and attempts of self-care than the typologies represented in the frequent use–low isolation and frequent use–isolated groups.

Infrequent Use–Isolated

Mr. Mason is an 86-year-old African American man who lives in a one-bedroom apartment in the downtown area of a large urban city. He has lived alone since his divorce more than 30 years ago. He and his ex-wife do not have children. Mr. Mason completed high school and worked as a janitor in office buildings until his retirement at age 65. After his retirement, he moved to the area where he currently resides. He has lived in his apartment for the past 5 years and knows some of the neighbors in his building. He does not have anyone he can consistently call on for help in an emergency. He recently found out that Medi-Cal will no longer pay for the Life Alert system he was using to contact an ambulance in case of an emergency. Thus, he had to return the equipment and can no longer afford the service.

Mr. Mason occasionally experiences discomfort related to chronic asthma, but his condition improved greatly after a VA nurse practitioner adjusted his asthma medication over 10 years ago. He uses inhalers to control symptoms related to asthma and checks in with his GRECC primary care physician during his routine clinic appointments. He visits the VA approximately twice a year for routine check-ups with his primary care physician and does not regularly receive care from specialists.
In the last 12 months, Mr. Mason visited the ER once, after falling and cutting his head while walking in his neighborhood. Two women witnessed the accident and helped Mr. Mason get back to his apartment. One of his neighbors suggested that Mr. Mason visit the VA to make sure he was alright. Although he was not experiencing a severe amount of pain, he agreed. His neighbor dropped him off at the VA ER that evening and told Mr. Mason to call him when he was discharged so that he could come pick him up.

All of the veterans in this group of low ER use and social isolation qualified as having low illness burden. In addition, the results of this study have supported the linking hypothesis in that those who had social support networks and who were involved in health care matters were more likely to be encouraged to seek medical care and ER care. These findings about the relationship between illness burden with ER use and social isolation with ER use may explain why none of the study participants fit into the category of infrequent ER users who were at high risk for social isolation and had high illness burden.

As a result of the lack of a comparison group, an examination of differences between the two illness burden groups in this group was not possible.

Veterans with infrequent ER use who were at high risk for social isolation did not have partners or close friends, but as with those at high risk for social isolation, frequent ER users could usually identify a neighbor or casual friend who could help in an emergency. ER visits were for accidents (involving bleeding, in the cases of these veterans) and the decision to go to the ER was made without much of an elaborate process or discussion with informal or formal social support network members.

**DISCUSSION**

This study purposely avoided judging the appropriateness of ER visits because its aim was to describe and explain older veterans’ ER use from the perspectives of the veterans themselves. Previous studies about ER use have found that providers and ER users seldom agree on what constitutes an emergency worthy of an ER visit (Ware, Brook, Davis, & Lohr, 1981; Wolcott, 1994). A limitation in this approach is that veterans’ self-reported reasons for ER use may not be entirely accurate or complete. Thus, data from medical records might be used to verify health-related reasons for self-reported ER use. Another limitation of the study is the small sample size, although a limited sample size is not uncommon in exploratory qualitative research.

There was a wide range of illness burden, risk of social isolation and frequency of ER use in this group of study participants. Each decision-making process not only changed from veteran to veteran, but also from visit to visit. Although the patterns for each group were described in more detail
earlier, the general patterns were as follows, organized by the three stages of decision-making:

- **Stage I: Problem Recognition.** Veterans identified events in which they: (a) recognized symptoms of a possible health problem on their own, (b) recognized symptoms at the same time someone else recognized them, or (c) did not recognize symptoms at all themselves, in which case someone else brought symptoms to their attention. Although almost all of the veteran participants had at least one chronic illness, those who were infrequent ER users were more likely to visit for symptoms resulting from accidents and unexpected injuries. Frequent ER users, conversely, were more likely to visit for acute symptoms associated with on-going or chronic medical conditions and were more likely than infrequent ER users to mention having the assistance of an informal or formal social support network member to decide if symptoms were indicative of a health problem.

- **Stage II: Decision to Seek Medical Care.** Decisions regarding what to do once symptoms of a health problem were characterized by one or more of the following processes: (a) wait-and-see, (b) self-care, (c) speaking with a social support network member for advice, (d) showing up at the VA without an appointment, and/or (e) visiting the ER (which then becomes Stage III) for medical attention. Veterans engaged in more than one of these behaviors to make a decision about what to do about the health problem.

- **Stage III: Decision to Seek Medical Care.** Veterans who used the ER frequently were more likely to visit because of an acute co-morbidity related to a long-term chronic illness. They engaged in an elaborate decision-making process when symptoms have progressed to a point when an ER visit was necessary. The role of social support networks in decision-making ranged from none at all to complete control. Some veterans described having little to no participation in the decision because a member of their social support network (most often a spouse, partner or a formal support member such as the veteran’s primary care physician) made the decision for them. Some veterans shared the decision-making with a friend, family member or health care provider. Others described situations in which they alone made the decision to go to the ER for their health problem, either due to a preference for making health decisions independently or due to a lack of social support network members.

**SOCIAL WORK IMPLICATIONS**

Proactively Addressing Frequent ER Use

The case studies presented in this article can help sensitize and alert social workers and other providers to the range of reasons an older veteran might visit the ER frequently. This study found that providers were often consulted
prior to an ER visit. Thus, providers may be especially effective in educating high-risk veterans about the full range of health and social services available (including ER care, when indicated). When providers are not available, such as during weekends or after hours, a nonemergency resource, such as a telephone nurse consultant, could assist older veterans with decision-making about their health problems.

Client Advocacy

This study’s findings suggest that veterans value their independence and autonomy when making a decision regarding health care matters. They include others when absolutely necessary, such as when pain becomes unbearable, as in the frequent use–isolated group. Although it may be important for the social worker to assist social support networks in navigating the health care system, the social worker should also be the guardian of self-determination for her client. That is, she must advocate for respecting that the veteran may want to be the main decision-maker. Thus, the social worker should be prepared to balance the needs of her client with the desires of family members and the VA system.

Social Support Groups

Several of the infrequent ER users with chronic illnesses attended VA support groups regularly. Perhaps weekly support obtained through VA-sponsored support groups helped the participating veteran better manage his chronic diseases, making ER visits less appealing. A review of research about medical cost offset (Chiles, Lambert, & Hatch, 1999) found that interventions aimed at serving psychosocial needs may reduce medical costs because people may seek medical care for psychosocial problems. Social workers should continue to explore the demand for and interest in psychosocial support for older adults, perhaps incorporating formal sources of support already playing a role in the lives of older ER users and their health care decisions, such as the Comprehensive Care Clinic offered as a pilot program by a group at the VA in Los Angeles (Carpiac, Guzman & Castle, 2007).

The veteran study group is a vulnerable population because of its probability of chronic comorbid conditions and lack of social support network to assist in an emergency. Frequent ER use is of concern because it is unclear whether or not an older veteran’s multifaceted needs can be met in an ER environment. Equal concern should be placed with the population of older veterans who do not visit the ER when they should. Future research should attempt to study the decision-making process of those who do not make it to the emergency room when their symptoms warrant it. For example, older veterans who have gone to the ER solely because of the recommendation of a provider during a regular appointment would be ideal participants for
such a study. Ultimately, these older veterans should be provided with specific education from either their primary provider or a member of the ER staff (i.e., nurse/social worker case managers) about improving the management of the veteran's chronic illness. Successful chronic illness management, however, may not eliminate ER visits. Even participants in this study whose chronic illnesses were well-managed through the GRECC needed to visit the ER for symptoms related to their chronic illness.

Last, future research should examine differences in decision-making based on gender and racial/ethnic group. Female veterans are a growing segment of the veteran population, and the VA is increasingly serving more female veterans. Past research about health care decision-making indicates significant differences between men and women in the decision to use the ER for health care needs. Additionally, as the veteran population is aging, it is also becoming more racially and ethnically-diverse. Definitions of health and wellness may be highly culturally-laden, and it is crucial to understand how veterans with diverse backgrounds make decisions about problem recognition, health care use, and ER use.

**SUMMARY**

This study examined older veterans' decisions to visit the ER and the role of social support network in the decision. Results suggested that encouragement by VA providers may contribute to a decision to visit the ER. More research would help explain the role of the system in promoting ER use. Older veterans from this study went through either a one-step or multiple-step decision-making process that led them to the ER, depending on the reason for their visit. Although they had people to help with this decision, many veterans wanted to make the decision independently. Others preferred to have little to do with the decision, allowing spouses and providers to make the decision for them. One's decision-making style might translate to other types of health care decision-making and should be taken into account by all providers who treat older veterans. Most of the ER visits by the frequent ER users in this study seem quite well-thought out. Hopefully, these findings will ease stigma associated with frequent ER use by this population.

**REFERENCES**


