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**Research Article**

# Nursing Role in Managing Patients with Recurrent Emergency Department Visits

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**Abstract:**

Nursing plays a pivotal and multifaceted role in breaking the cycle of recurrent Emergency Department (ED) visits by addressing the complex biomedical, psychological, and social determinants that drive this high-risk behavior. Moving beyond episodic crisis intervention, nurses employ holistic assessments to identify root causes such as unmet mental health needs, medication non-adherence, and socioeconomic instability. Through skilled care coordination and transitional planning, they bridge the critical gap between the ED and community-based services, ensuring seamless linkages to primary care, social support, and chronic disease management programs. The therapeutic nurse-patient relationship, built on trust and motivational interviewing, fosters engagement and empowers patients with tailored education for improved self-management. Furthermore, nurses lead interdisciplinary initiatives and advocate for systemic reforms, positioning them as essential agents in transforming the ED from a revolving door into a portal to sustainable, patient-centered health outcomes.

## 1. Introduction

The modern Emergency Department (ED) serves as a critical nexus within the healthcare system, designed to manage acute, life-threatening conditions and unforeseen medical crises. However, a growing and complex patient population challenges this primary function: individuals with recurrent Emergency Department visits. Often termed "frequent flyers" or "high utilizers," these patients present a multifaceted problem that intersects clinical medicine, public health, social work, and health economics. Defined variably in literature, but commonly as individuals with four or more ED visits annually, this group, which constitutes a small percentage of the overall patient population, is responsible for a disproportionately large share of ED encounters and associated healthcare costs [1, 2]. Their patterns of utilization signify not merely personal health choices but frequently represent systemic failures, unmet social determinants of health, and poorly managed chronic disease pathways.

The phenomenon of recurrent ED use is a symptom of deeper, often fragmented, healthcare delivery. Patients within this cohort are typically characterized by a high burden of chronic medical conditions—such as congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes, and renal disease—coupled with significant psychiatric comorbidities including substance use disorders, depression, and anxiety [3, 4]. Beyond biomedical factors, a thick layer of psychosocial complexity is almost invariably present. Issues such as homelessness or unstable housing, low health literacy, social isolation, lack of reliable primary care, and economic hardship create a perfect storm that funnels individuals toward the ED as a default source of care [5]. The ED, operating on a principle of episodic and urgent intervention, is structurally and philosophically ill-equipped to address these longitudinal, root-cause issues. This mismatch leads to a cycle of costly, suboptimal care that fails to improve patient outcomes while contributing to ED overcrowding, staff burnout, and inefficient resource allocation [6].

Traditionally, the response to frequent ED use has leaned towards punitive or restrictive measures, such as care plans flagging patients for limited services or viewing them through a lens of behavioral problem. This approach has proven largely ineffective and ethically questionable, as it fails to address underlying needs and may exacerbate health disparities [7]. A paradigm shift is essential, moving from a view of "inappropriate use" to one of "high need." This is where the unique and expansive role of nursing becomes not just valuable but indispensable. Nursing, with its foundational ethos of holistic, patient-centered care, bridges the chasm between acute intervention and long-term health management. The nursing process—assessment, diagnosis, planning, implementation, and evaluation—provides a robust framework for engaging this population beyond the immediate presenting complaint [8].

### 2. Identification and Comprehensive Assessment: The Nursing Foundation

The initial and perhaps most critical step in altering the trajectory of a frequent ED user is accurate identification and a subsequent comprehensive, nuanced assessment that looks beyond the chief complaint. Triage nurses are the first point of contact, and their observational skills are paramount. While registration data can flag patients based on visit frequency, it is the nurse's clinical judgment that begins to discern patterns—recognizing a familiar face presenting with another exacerbation of a known condition, or noting the vague, non-specific complaints that may mask deeper psychosocial distress. This frontline

recognition initiates a tailored approach from the very onset of the ED encounter [9].

However, identification is merely the precursor to a deliberate and holistic nursing assessment. For the recurrent visitor, the standard ED assessment must be intentionally expanded. This involves a structured yet compassionate inquiry that explores the multidimensional factors contributing to ED reliance. Nursing assessments should systematically evaluate not only the acute medical issue but also the patient's chronic disease management, medication adherence, mental health status, substance use, functional capacity, and social support systems. Tools such as brief screening questionnaires for health literacy, depression (e.g., PHQ-2/9), anxiety, and substance use can be integrated into the nursing workflow to uncover hidden contributors [10]. A meticulous medication reconciliation, far from a clerical task, is a clinical investigation that often reveals polypharmacy, misunderstanding of regimens, or an inability to afford prescriptions—all direct pathways back to the ED [11].

Crucially, this assessment employs motivational interviewing (MI) techniques, a client-centered communication style that explores ambivalence and enhances intrinsic motivation for change. Instead of a paternalistic interrogation ("Why do you keep coming here?"), nurses using MI engage in collaborative conversation ("What has made it challenging to manage your condition at home?" or "What would need to be different for you to feel you could handle this without coming to the ED?"). This approach builds rapport, reduces defensiveness, and yields more authentic information about the patient's barriers, goals, and readiness to engage with alternative services [12]. The product of this nursing assessment is a rich, personalized understanding of the patient's ecosystem. It shifts the diagnostic focus from the disease to the illness experience, identifying actionable targets for intervention such as unmet social needs (e.g., food insecurity, transportation), gaps in medical follow-up, or untreated psychiatric symptoms. This foundational work transforms the patient from a "high utilizer" statistic into an individual with a unique story and specific, addressable needs, setting the stage for all subsequent interventions [13].

### 3. Care Coordination and Transition Planning: Orchestrating Seamless Care

For patients caught in a cycle of ED visits, discharge often represents not an endpoint but a precarious transition back into a system that has previously failed them. The nursing role in orchestrating a safe and effective discharge is therefore a linchpin intervention. For the recurrent visitor, standard discharge instructions are grossly insufficient. Nursing-led care coordination and transition planning must actively bridge the gap between the episodic ED care and longitudinal community-based support, transforming the discharge process from an administrative event into a therapeutic linkage [14].

This process begins early in the ED stay, concurrent with assessment. The nurse, acting as a central hub, initiates referrals and communications with a network of community resources. This may involve contacting the patient's primary care provider or specialty clinic to secure a timely, actionable follow-up appointment—sometimes even before the patient leaves the ED. Nurses coordinate with hospital-based case managers or social workers to address urgent social determinants, such as arranging temporary shelter for a homeless patient or connecting them with food assistance programs [15]. For patients with complex medication regimens, nurses may facilitate enrollment in medication assistance programs or collaborate with pharmacists for simplified dosing or blister packs. The use of health information technology, where available, to send alerts or summaries to the patient's medical home is another critical coordination function [16].

A cornerstone of this nursing role is the creation of a patient-centered, concrete, and understandable after-care plan. This plan, developed *with* the patient rather than *for* them, goes beyond a piece of paper. It includes clear, written instructions in the patient's preferred language and at an appropriate literacy level, a reconciled and understandable medication list, specific names and contact information for follow-up providers, and explicit "red flag" symptoms that warrant a return to the ED versus those that can be managed through a new primary care contact or nurse advice line [17]. The nurse ensures the patient can verbalize key components of the plan, employing the teach-back method to confirm comprehension. Furthermore, proactive post-discharge follow-up, such as a nurse-led telephone call within 48-72 hours, has shown significant efficacy in reducing readmissions and subsequent ED visits. This call allows for troubleshooting new problems, reinforcing the care plan, confirming appointment attendance, and reinforcing the patient's connection to a supportive resource, thereby preventing small issues from escalating into crises that lead back to the ED [18].

### 4. Therapeutic Communication and Trust-Building: The Relational Cornerstone

The clinical and logistical interventions described are fundamentally dependent on one critical element: a therapeutic nurse-patient relationship. For many recurrent ED users, experiences with the healthcare system have been characterized by stigma, dismissal, frustration, and fractured relationships. They may be labeled as "difficult," "non-compliant," or "manipulative," leading to defensive interactions that reinforce negative cycles [19]. Nursing, with its core value of unconditional positive regard, is uniquely positioned to break this cycle through intentional, skilled therapeutic communication that establishes trust—the essential currency for change.Building trust with this population requires consistency, empathy, and authenticity across encounters. It means recognizing the patient as an individual beyond their utilization pattern, remembering their name and key aspects of their story. Nurses demonstrate empathy by acknowledging the patient's frustration and the real challenges they face, validating their experience even when the ED may not be the most appropriate setting for their needs. Statements like, "I can see how frightening it is when your breathing gets tight, and it makes sense you came here for help," build alliance rather than creating opposition [20]. This approach requires emotional intelligence and resilience from nurses, who must manage their own potential frustration or bias to maintain a professional, compassionate stance.Therapeutic communication also involves setting clear, compassionate boundaries. This is not about being permissive but about being predictable and fair. A nurse might say, "My role today is to help stabilize your pain and then work with you on a plan to manage it better long-term with your pain specialist. Let's focus on that together." This frames the interaction as collaborative and goal-oriented. For patients with behavioral health or substance use issues, de-escalation techniques and trauma-informed care principles are vital components of communication. Trauma-informed care recognizes the high prevalence of past trauma in this population and seeks to avoid re-traumatization by creating a sense of safety, choice, and empowerment in clinical interactions [21]. By fostering a relationship based on respect and trust, the nurse becomes a credible source of information and guidance. This trust increases the likelihood that the patient will accept referrals, adhere to follow-up plans, and view the nurse as a partner in navigating their health challenges, thereby reducing the felt need to seek solace and solution solely in the ED [22].

## 5. Patient and Family Education: Fostering Self-Management Empowerment

A primary driver of recurrent ED visits is a gap in self-management capabilities, often stemming from low health literacy, fear, or a lack of confidence in managing symptoms at home. The ED environment, with its time pressures, is notoriously challenging for effective education, yet for the frequent utilizer, it represents a critical—and perhaps the only—point of contact. Therefore, nursing must seize this opportunity to deliver targeted, reinforced, and actionable patient and family education aimed at building health literacy and self-efficacy [23].

Education for this population must be hyper-personalized, moving from generic disease handouts to interactive, scenario-based learning. Using the "teach-back" or "show-me" method is non-negotiable; it is the only reliable way to confirm understanding. For a patient with heart failure, education is not complete when the nurse simply says, "limit your fluids and weigh yourself daily." Instead, the nurse engages the patient in a dialogue: "Can you show me how you will measure your fluids tomorrow?" or "What weight gain over two days would prompt you to call your heart failure nurse before coming to the ED?" [24]. This shifts knowledge from passive receipt to active application. Nurses must also educate on "when to worry," providing clear, specific guidance on which symptoms necessitate an ED visit versus those that can be managed with a scheduled clinic appointment, a call to a advice line, or self-care actions. This empowers patients to make more appropriate decisions about seeking care [25].

Furthermore, education extends to navigating the healthcare system itself. Many patients rely on the ED because they do not know how to access or effectively use primary care. Nurses can educate patients on the role of a primary care provider, how to schedule and prepare for appointments, how to use patient portals, and the availability of after-hours clinic services or nurse advice lines. For caregivers and family members, education focuses on support strategies, recognition of warning signs, and how to access respite services to prevent caregiver burnout—a common precursor to ED visits for dependent patients [26]. By embedding empowerment-based education into every interaction, nurses equip patients with the tools and confidence to become managers of their own health, reducing helplessness and dependence on the emergency safety net.

## 6. Leadership in Interdisciplinary and Community-Based Initiatives

While individual nurse-patient interactions are powerful, the systemic nature of the frequent ED use problem demands systemic solutions. Nurses

are increasingly taking leadership roles in designing, implementing, and evaluating interdisciplinary and community-based programs aimed at this population. Their frontline perspective and holistic understanding make them indispensable contributors and leaders in these initiatives [27].

Within the hospital, nurses are key members of, and often lead, interdisciplinary care coordination teams. These teams, which may include physicians, social workers, pharmacists, behavioral health specialists, and community health workers, develop and manage complex care plans for identified high-utilizers. The nurse often serves as the consistent point of contact for the patient, coordinating the team's efforts, monitoring the patient's progress, and providing longitudinal support. They champion initiatives like embedding psychiatric liaison nurses in the ED to provide immediate assessment and linkage for patients with mental health crises, preventing a revolving door of incomplete referrals [28].

Beyond the hospital walls, nurses lead and staff innovative community-based models. A prime example is the Nurse-Led Care Management or Transitional Care Model. In this model, advanced practice nurses or experienced RNs maintain a caseload of high-risk patients, providing intensive, home-based or telephonic support after an ED visit or hospitalization. They conduct home visits, manage medications, provide intensive education, and coordinate with all providers, effectively creating a wraparound service that addresses medical and social needs proactively [29]. Similarly, nurses are integral to community paramedicine or mobile integrated health programs, where they partner with paramedics to perform home safety checks, medication reconciliation, and follow-up assessments for patients recently discharged from the ED, ensuring stability in the home environment [30].

At a macro level, nurse leaders advocate for policy changes that support these models, such as reimbursement for nursing care coordination services, expanded scope of practice for advanced practice nurses, and funding for addressing social determinants of health. By moving into these strategic and operational roles, nurses leverage their expertise to redesign care systems, making them more responsive, integrated, and preventive for the patients who need it most [31].

## 7. Addressing Specific Populations: Tailoring the Nursing Approach

The cohort of recurrent ED users is not monolithic; distinct subgroups require tailored nursing approaches to address their unique etiologies of high utilization. A one-size-fits-all strategy is ineffective. Specialized nursing knowledge and skills are paramount in adapting core interventions to meet the specific needs of patients with severe mental illness, complex chronic conditions, and the elderly [32].

For patients with severe and persistent mental illness (SPMI) such as schizophrenia or bipolar disorder, recurrent ED visits often stem from psychiatric decompensation, medication non-adherence, or co-occurring substance use, exacerbated by fragmented mental health systems. The nursing approach here is deeply rooted in psychiatric-mental health nursing principles. Building a trusting relationship is paramount, requiring exceptional patience, consistency, and non-judgmental communication. Nursing assessments carefully evaluate mental status, medication efficacy and side effects, substance use, and social stability. Nurses act as vital liaisons with community mental health centers, assertive community treatment (ACT) teams, and case managers to ensure continuous psychiatric care. They provide psychoeducation to patients and families about illness management and early warning signs of relapse, and they are skilled in de-escalation techniques during crises. The goal is to integrate mental and physical health care, recognizing that neglect of either domain fuels ED utilization [33].

Patients with multiple complex chronic conditions, such as heart failure, COPD, and renal disease, often visit the ED due to acute exacerbations. The nursing focus is on intensive disease-specific self-management education and meticulous care coordination. Nurses employ advanced assessment skills to detect subtle signs of deterioration. Education is highly specific—for the COPD patient, this includes teaching pursed-lip breathing techniques and energy conservation; for the heart failure patient, it involves daily weight monitoring and fluid management. Nurses coordinate closely with specialty clinics (e.g., heart failure clinics, pulmonary rehab) and home health agencies to ensure seamless transitions. They empower patients with action plans that specify exactly what to do when symptoms worsen, including when to take rescue medications and when to call for help, thereby preventing minor exacerbations from becoming emergencies [34].

The elderly population presents with a confluence of medical complexity, polypharmacy, functional decline, and social isolation. Geriatric nursing expertise is crucial. Nursing assessments for older adults must include functional status (using tools like the "Timed Up and Go" test), fall risk,

cognitive screening (for delirium or dementia), and evaluation of social supports. A meticulous review of medications for inappropriate prescribing or interactions is a critical intervention. Nurses address issues like advance care planning, helping patients articulate their goals of care to avoid unwanted, aggressive interventions in future crises. They coordinate with geriatric care managers, adult day health centers, and home-based services to create a supportive network that enables aging in place safely. For this group, the nursing role is fundamentally about preserving function, managing frailty, and connecting to community resources that mitigate isolation and risk [35].

## 8. Evaluation of Outcomes and Ethical Considerations

To ensure that nursing interventions for recurrent ED visitors are effective, justified, and ethically sound, a robust framework for outcome evaluation and ongoing ethical reflection is essential. Nursing's role extends beyond implementation to measuring impact and navigating complex moral dilemmas inherent in working with this vulnerable population [36].

Evaluating outcomes requires moving beyond simple metrics like reduced ED visit counts. A comprehensive nursing evaluation employs a balanced set of indicators. Process measures assess the fidelity of interventions (e.g., percentage of identified patients receiving a comprehensive nursing assessment, completion rates of post-discharge follow-up calls). Outcome measures should be patient-centered and multidimensional: these include clinical outcomes (e.g., improved disease control metrics like HbA1c or blood pressure, reduced hospitalization rates), functional status improvements, patient-reported outcomes (e.g., improved health-related quality of life, increased self-efficacy measured by tools like the Patient Activation Measure), and experience-of-care measures (e.g., patient satisfaction with care coordination) [37]. Economic analysis, while complex, is also relevant to demonstrate cost-effectiveness or cost-avoidance from a systems perspective. Nurses contribute to this evaluation by meticulously documenting interventions and patient responses, participating in quality improvement projects, and advocating for the use of meaningful outcome measures that reflect holistic nursing contributions [38].

Concurrently, nursing practice in this arena is fraught with ethical considerations that require constant vigilance. The principle of justice is central, as these patients often belong to marginalized groups. Nurses must guard against implicit bias and stigmatizing language, ensuring equitable care regardless of utilization history. The tension between patient autonomy and beneficence is common. A patient may autonomously choose to return to the ED for non-urgent needs, while the nurse believes a primary care referral is more beneficial. This requires skillful motivational interviewing and shared decision-making rather than coercion. Issues of resource allocation arise, particularly in crowded EDs; nurses must balance the needs of the frequent visitor with those of other acutely ill patients, avoiding both neglect of the former and disproportionate resource expenditure at the expense of the latter [39].

Confidentiality and the use of flags or care plans pose another ethical challenge. While information sharing among providers is crucial for care coordination, special alerts in medical records can lead to prejudice and substandard care from other team members. Nurses must advocate for systems that facilitate compassionate, coordinated care without stigmatizing labels. Ultimately, an ethical approach is grounded in the nursing ethic of care, which emphasizes relationship, context, and responding to the patient's unique needs without judgment, striving always to understand the person behind the pattern of visits [40].

## 9. Conclusion

The challenge of recurrent Emergency Department visits represents a critical failure point in the healthcare continuum, reflecting unmet medical, psychological, and social needs. As this essay has delineated, the nursing profession is uniquely and powerfully positioned to address this multifactorial problem. Through skilled holistic assessment, nurses uncover the root causes driving ED reliance. As master coordinators, they orchestrate seamless transitions and link patients to sustainable community resources. Employing therapeutic communication, they build the trust necessary for behavioral change. Through empowering education, they foster self-management competence. In leadership roles, they design and implement systemic solutions like care management programs. By tailoring approaches to specific high-need populations and rigorously evaluating their impact within an ethical framework, nurses demonstrate that their role is not ancillary but central to a solution.

Addressing frequent ED use is not about denying access to emergency care but about creating a more effective, humane, and efficient system that delivers the right care, in the right place, at the right time. This requires a shift from episodic, crisis-oriented intervention to proactive, relationship-

based, and continuous care management. Nurses, operating at the intersection of acute care and public health, are the essential catalysts for this shift. Their holistic philosophy, combined with concrete skills in coordination, communication, and patient advocacy, allows them to break the cycle of recurrent visits, improve individual health outcomes, and contribute to the sustainability of the emergency care system. Investing in and fully leveraging the nursing role is therefore not merely a clinical strategy but an ethical and economic imperative for modern healthcare.

## Author Statements:

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