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Background and Significance. It is necessary to improve patient outcomes with older adults who present to the emergency department (ED). Patient-centered care strives to improve older adult outcomes from the ED. However, appropriate disposition decisions with older adults are becoming increasingly complex and challenging to achieve.

Purpose. The purpose of this study was to explore the perceptions of older adults as to their disposition from the emergency department, the decision making process, and their engagement in that process. It also explored factors that older adults identify as important when making a disposition decision from the emergency department. This study utilized a conceptual Three-Talk Shared Decision Making model to guide the study.

Methods. The research design utilized in the study was a descriptive qualitative approach. Recently discharged older adults treated in the emergency department agreed to a telephonic interview. Audiotapes were transcribed and thematically analyzed to identify codes, patterns, and themes.

Findings. The study's analysis revealed that the process of the Three-Talk Shared Decision Making model was not evident for this sample of older adults seeking care in the ED. Participants identified only one option regarding their disposition from the ED. Consequently, the participants did not identify the process of option talk. The emergent themes, emotional reactions, helplessness, and provider empathy provided insight into

how older adults perceive their disposition decision. The three factors participants perceived as vital to them before making a disposition decision were safety, pain relief, and a definitive diagnosis.

Discussion and Recommendations. The study revealed that older adults want to be heard regarding their treatment and disposition decisions. The study identified the importance of provider education when deciding treatment or disposition decisions with the older adult. It revealed a need to promote the utilization of the Three-Talk Shared Decision Making Model to improve patient-centered care and ED disposition outcomes.

Recommendations include future qualitative studies to be conducted with both the older adult and provider's perception of the ED visit. Additional strategies and skills are warranted to enhance shared decision making in the ED with the growing aging population. With the recent SARS-CoV-2 pandemic, older adults are at high risk for increased ED visits, and the decision making process may become increasingly complicated as this population continues to age.

Keywords: aged, elderly, disposition, frailty, emergency department, disposition, transition, comorbidities

OLDER ADULTS' PERCEPTIONS OF DISPOSITION DECISIONS FROM THE EMERGENCY DEPARTMENT

by

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Approved by

_____
Committee Chair

To my Husband Michael

To my sons, Joseph, Michael Jr., John, David

To my favorite daughter, Mary

In Memory of my brother, William

APPROVAL PAGE

This dissertation, written by Karen Valcheff, has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

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CHAPTER I

INTRODUCTION

The use of the emergency department (ED) is growing and as the older population grows so does their utilization of the ED (Castillo et al., 2019). Based on the National Hospital Ambulatory Medical Care Survey (2017) results, older adults comprised 32.2% of all ED visits (Rui & Kang, 2017). According to the Centers for Medicare and Medicaid Services (CMS, 2019), the older adult population constitutes 15% of the entire population, yet this population represents 34% of health care costs, over double the population represented.

The number of older adults in the United States (U.S.) population is expected to increase from 49 million in 2016 to 71 million in 2030 (Centers for Disease Control and Prevention [CDC], 2020). In 2017 there were 45 million older adults in the U.S. population (U.S. Census Bureau, 2017a, 2017b), and according to the North Carolina Department of Health and Human Services (2018), North Carolina ranks ninth in the nation in terms of the number of adults aged 65 and over. By 2025 North Carolina projects older adults over 65 will represent one in every five persons (North Carolina Department of Health and Human Services, 2018). By 2050 there may be more than 90 million older adults in the U.S. population (U.S. Census Bureau, 2017a, 2017b), and that rise may have a significant impact on healthcare spending in the future, including Medicare spending.

With the aging of the “baby boomer” population Medicare enrollments are expected to rise and Medicare expenditures to increase at a rate of 7.6% every year until 2028 (CMS, 2020). Per capita Medicare spending is expected to increase yearly at a rate of 5.1% over the next 10 years (Cubanski et al., 2019). Continued Medicare spending is projected to increase from $630 billion in 2019 to $1.3 trillion in 2029 (Cubanski et al., 2019). As the older population grows so does their ED utilization (Castillo et al., 2019). Multiple increased ED visits contribute to higher healthcare costs**.**

The rate at which older adults visit and revisit EDs is increasing more than the rate of any other population group (Berning et al., 2020; Ellis et al., 2014; Shankar et al., 2014). Gelder et al. (2018) identified that 10% of the older population returns to the ED within a 30-day discharge from their initial visit. In one analytic study, conducted in Finland, “heart failure, atrial fibrillation, pneumonia, abdominal pain, and urinary retention” (Ukkonen et al., 2019, p. 3) were identified as the most common diagnoses for older adults who account for multiple ED visits. Coe et al. (2018) found abdominal and back pain and headaches to be the most common non-emergent reasons for a visit to the ED by the older adult.

Even though older adults are most likely to use ED services, the complexity of their care—due frequently to multifaceted chronic illness as well as functional disabilities—often makes care, such as the disposition decision, challenging to coordinate and integrate (Lafortune et al., 2015). Older adults often have additional comorbidities and the need for additional resources and increased procedures requiring longer lengths of stay, resulting in increased costs (Greenwald et al., 2016).

According to the Administration for Community Living (2020) the most frequent chronic comorbidities include heart disease, diagnosed and undiagnosed diabetes, cancer, stroke, arthritis, and hypertension. Moreover, impairments such as hearing, visual, or mobility deficits most often found in the older adult population complicate the ED's disposition decision (Administration for Community Living, 2020). In a retrospective, longitudinal, cohort study using a database that included 326 hospitals, Castillo et al. (2019) identified that older adults who are repeat users of the ED have multiple comorbidities.

Older adults often present to the ED with one or more comorbidities and are taking multiple medications, factors requiring additional diagnostics and resources prior to a disposition decision (Pines et al., 2013). It costs more for an older adult with multiple chronic comorbidities to visit the ED than to see a primary care provider in an office visit; however, older adults with multiple chronic conditions often visit and revisit EDs (Hunold et al., 2014). Chronic conditions are associated with longevity, which is rising, and increased difficulty with activities of daily living (Olivari et al., 2018). If older adults are unable to care for themselves and socialize, then their quality of life can decrease (Sánchez-García et al., 2017). When illness and injury require an ED visit by the older adult, that visit can lead to negative patient outcomes, such as reduced functional activities (Nagurney et al., 2017). An ED visit for an older adult often raises the risk of adverse events (Lowthian et al., 2015) as well as leads to functional decline, and poorer quality of life (Wei et al., 2019). Kojima et al. (2020) recognized that organs start to lose function with age, especially with multiple comorbidities requiring additional

individualized patient care to prevent adverse outcomes such as additional ED visits. To meet older adults' needs and identify those at most risk for negative outcomes after an ED visit, other programs of care are warranted (Latham & Ackroyd-Stolarz, 2014).

Disposition decisions that are not tailored to meet each older adult patient's individual needs can result in additional ED visits or hospitalizations (Nagurney et al., 2017). Such revisits to the ED will further strain patients, their families and caregivers, and the healthcare system (Earl-Royal et al., 2017). Additionally, high utilization of the ED by older adults is problematic because it is directly correlated with negative outcomes (Dermody et al., 2017).

Disposition decisions in the ED often emphasize more immediate and short-term factors in recovery rather than long-term factors that may affect the patients' ability to meet their activities of daily living (Provencher et al., 2015). Disposition decisions that meet short-term needs may occur because older adults sometimes present to the ED with minor complaints (Nagurney et al., 2017). However, disposition decisions that attend only to short-term factors may not account for the additional limitations of many older adults, including comorbidities, frailty, and both financial and social burdens (Burton et al., 2014; Provencher et al., 2015). For example, when emergency departments make decisions about the disposition of patients, they often do not consider the self-care problems that may be encountered by older adults who are frail (Quinn et al., 2019). Additional screenings for comorbidities, such as frailty, may help to reduce ED revisits if appropriate interventions and support are provided through a shared decision making process (Ramdass et al., 2018).

While there have been system-oriented examinations of older adults using the ED and the disposition, there has been minimal recognition given to patients' understanding of the ED provider's disposition decision (Marr et al., 2019) or how patients are involved in those decisions. The implementation of patient-centered care for older adult requires recognition of their individualized needs (American Geriatrics Society Expert Panel on Person-Centered Care, 2016). Patients' perceptions of their experiences and their engagement with their disposition decision from the ED may be used to close the gap between positive patient outcomes and those outcomes requiring additional revisits to the ED or outcomes that lead to the continuing deterioration of the older adult.

Problem Statement

Despite extensive literature identifying patients' experiences in the ED, little primary scientific evidence has been identified in published literature about patient perceptions of the disposition decision from the ED (Vaillancourt et al., 2017). It is important to understand how to effectively manage disposition decisions from the ED to provide a smooth disposition transition and reduce ED revisits (Rising et al., 2016). Identifying factors that affect the ED disposition decisions of the older adult from the patient perspective is critical to providing individualized care that will result in positive patient outcomes while lowering healthcare costs for Medicare patients (Steinmiller et al., 2015).

Purpose of Study

Based on the problem identified and the limitations in previous research, the purpose of this study was to explore the perceptions of older adult ED patients as to the

disposition from the ED, the decision making process and their engagement in that process. Better understanding of older adult patients' perceptions of and involvement in the process of the disposition decision may contribute to improved disposition decisions, improved patient outcomes, reduction in ED visits, improved patient satisfaction, and ultimately decreased healthcare expense. Understanding the factors that patients perceive as important to the decision making process will assist with implementing disposition strategy changes that will improve the quality of care while reducing healthcare costs.

Conceptual Framework

The Three-Talk Model of Shared Decision Making (SDM) (Elwyn et al., 2017, Appendix A) adapted for a clinical setting is the conceptual framework for this study because of its simplicity to integrate with an older adult population and its focus on decision making—a key component for older adult care success. According to the Institute of Medicine (IOM, 2011), patient-centered care may need to entail a joint effort between providers, patients, and caregivers to share the decision making process and thereby achieve positive patient outcomes. The Agency for Healthcare Research and Quality (AHRQ) acknowledges as a priority the need for improved communication and effective coordination of care that include disposition decisions from the ED (AHRQ, 2019). Through the Three-Talk SDM model providers can promote engagement with their patients to develop effective disposition decisions (Elwyn et al., 2017).

The SDM model is useful when deciding the discharge dispositions of the older adult from the ED because the SDM facilitates collaboration and communication, and those practices may lead to patient-centered dispositions (Charles et al., 1997; Hess et al.,

2015). To effectively manage disposition decisions from the ED and reduce ED revisits, providers need to collaborate with their patients (Rising et al., 2016). Providers may fail to consider older adults' overall needs because they are not in the habit of collaborating with patients during the disposition process (Rising et al., 2016). Moreover, Lamb et al. (2019) conducted a quantitative study of 330 physicians and found that the SDM process is especially important for those patients with comorbidities as far as collaborative decision making increases the patients' adherence to their health care regime, ultimately increasing their quality of life and decreasing ED visits. In addition, the Three-Talk SDM model entails the provider offering information to the patient based on the best evidence-based practices; it also entails the provider and patient can carry out the healthcare decisions jointly (Elwyn et al., 2012; Ouchi et al., 2018). It increases collaboration and provides equity between the provider and the patient (George et al., 2016).

The Three-Talk SDM model includes information sharing, developing mutual trust, comparing different treatment options, and giving the patient a vital role in implementing those options (Elwyn et al., 2017). The consequences of good, shared disposition decisions include increased patient satisfaction with the decision and positive patient outcomes (Schoenfeld, Radecki et al., 2018). In contrast, consequences of disposition decisions that are not made collaboratively are poor patient outcomes, increased ED revisits, hospitalizations, and death (Wei et al., 2019).

Patients most frequently returned to the ED because of fear and uncertainty about their condition (Rising et al., 2016). Patients who present have feelings of uncertainty causing them to be afraid of the unknown (Rising et al., 2016). Rising et al. (2016), in a

qualitative study of ED patients, found fear as a factor when patients have a disposition decision without a definitive diagnosis or unrelieved symptoms. Increasing the collaboration and decision making between the patient/caregiver and provider can help alleviate the uncertainty (Schoenfeld et al., 2016). In a more recent study conducted by Thomas et al. (2018), of 27 psychiatric participants who participated in focus groups shared decision making was an important quality with their disposition decision.

Emergency department providers and nurses are often involved with the decision making process with their patients/caregivers, and these decisions can impact the patient outcome (Ouchi et al., 2018). Collaboration and communication between the patient and the provider and the entire treatment team can improve the consistency and quality of care (Morrison, 2016). The utilization of the Three-Talk SDM model opens an avenue for increased collaboration between the ED provider and the patient and in turn results in positive patient outcomes (Medford-Davis et al., 2018). The Three-Talk SDM model was used to develop the data collection guide for this study. In addition, the Three -Talk SDM model was used for the analysis of the first research question.

Research Questions

Based on the problem identified, this study will explore the perceptions and engagement of older adult emergency department (ED) patients as to their disposition decision making process from the ED. The following are the research questions for this study:

RQ1. What are older adults' perceptions of their direct engagement in the decision making process related to their disposition from the emergency department?

RQ2. How do older adults who present to the emergency department for care perceive the discharge decision making process and disposition decision from the emergency department?

RQ3. What factors do older adults identify as important when making the decision about their disposition from the emergency department?

Terms

The following terms are central to this study. The definitions explain how the terms are used in the study.

Comorbidities—Comorbidities denote the presence of two or more chronic diseases (Mata-Cases et al., 2019).

Disposition decision—A disposition decision denotes a decision made by a provider to discharge a patient from the ED (Calder et al., 2015). For this study, the discharge disposition includes the following types of placement: (a) skilled nursing facility placement, (b) assisted living placement, (c) discharge to home (Calder et al., 2015), or (d) observation unit.

Disposition planning—Disposition planning denotes the process of deciding how to accurately provide patients with the resources they need after ED treatment (Perimal-Lewis et al., 2015).

Patient Engagement—Interactions between the provider and patient collaborating to make important decisions involving their healthcare treatment (Simmons et al., 2014).

Older or elderly adult—An older adult is a person 65 years of age and over; the terms older adult and elderly adult will be used interchangeably (Steinmiller et al., 2015).

Transition or discharge—Transition or discharge relates to the process whereby the patient leaves the original care setting (the ED) and moves to another care setting (Calder et al., 2015).

CHAPTER II

LITERATURE REVIEW

In this chapter, a review of the literature related to older adult disposition decisions from the emergency department (ED) is provided. The following themes emerged from the review of literature and are presented in this chapter: (a) patient engagement in disposition decisions, (b) provider and nurse engagement in disposition decisions, (c) comorbidities and disposition decisions, (d) overcrowding and disposition decisions, and (e) health literacy and disposition decision. Presenting information on those five themes in this chapter, the challenges and needs facing not only older adult patients within the ED but also the healthcare system in general are described. In addition, an overview is included of the Three-Talk Shared Decision Making (SDM) model utilized as the framework for the interview questions for this study.

A systematic search of PubMed and CINAHL was conducted to locate articles that would identify factors that affect ED disposition decisions for the older adult. Scholarly articles that met the following criteria were included in the review: the research was conducted on a sample of people 65 years old and older; the research was conducted on a sample that visited or revisited the ED, and the article was written in the English language. Articles meeting any of the following criteria were excluded: the research sample contained patients in hospice or who had been diagnosed with dementia. Articles published more recently were considered first; thus, most of the articles that were

reviewed were published within the last 5 years. Older articles were included when they were foundational or necessary for historical context.

The process of identifying articles occurred in two phases. First, the following MeSH terms were used to search CINAHL and PubMed for articles related to older adults and their disposition decision; “aged,” “elderly,” “disposition,” “frailty,” “emergency department,” “disposition,” “transition,” and “comorbidities.” The second search of CINAHL and PubMed was designed to identify articles related to the SDM model; thus, the following MeSH terms were used: “shared decision making,” “patient involvement,” “emergency department,” and “disposition and decision.”

Older Patients and ED Visits

One of the fastest growing populations is adults aged 65 and older (U.S. Census Bureau, 2020). Annually, over 20 million older adults obtain care from the ED (Schumacher & Chrisman, 2020). The older adult population is one of the ED’s most frequent users (Ellis et al., 2014). Managing the older adult in the ED is complicated for multiple reasons, including comorbidities, multiple medications, use of multiple pharmacies, and problems with communication (Dermody et al., 2017; McClelland & Sorrell, 2015). While in the ED older adults use more resources and stay longer than other populations (Ellis et al., 2014); the complexities of older adult patients in the ED often result in higher healthcare costs for not only Medicare but also for the older adults themselves (Lafortune et al., 2015; Provencher et al., 2015). In addition to these higher costs, CMS has changed its reimbursement policies and placed more emphasis on quality measures, changes that further complicate the way older patients are treated in the ED

(Carpenter et al., 2014). The financial challenges older adults experience because of ED visits can also affect their outcomes (Provencher et al., 2015). Using more resources and staying longer in the ED are correlated with negative patient outcomes such as ED revisits, hospitalizations, and high mortality rates (Ellis et al., 2014).

Disposition decisions from the ED are especially critical among adults aged 65 and older (Misch et al., 2014; Zubritsky et al., 2013). Before the 1970s providers caring for older adults concentrated on long-term care and gave little attention to acute care of older adults seeking treatment at the ED (Lowenstein et al., 1986). One of the first studies to acknowledge the use of the ED with older adults was Lowenstein et al.'s (1986) prospective pilot study comparing ED usage by older adults with usage by a population age 65 and under. They identified that older adult healthcare utilization in the ED was associated with longer waiting times, increased diagnostic testing, increased admission rates, and increased revisits to the ED within a 2-week period following ED discharge.

Studies conducted as far back as 2004 have identified disposition decisions as challenging to make and at times the decisions that are made are inappropriate to meet the needs of the older adult (Guttman et al., 2004). Options for older adult disposition from a hospital ED include the following: (a) inpatient admission, (b) observational unit admission for 24 hours, (c) skilled nursing facility placement, (d) assisted living placement, or (e) discharge to home (Calder et al., 2015). Older adult utilization of the ED is expected to increase as the older population continues to grow (McCusker et al., 2018), and high utilization of the ED by older adults is problematic because it is directly correlated with negative outcomes and increased healthcare costs (Dermody et al., 2017).

When providers effectively manage disposition decisions from the ED, they provide a smooth discharge process and reduce ED revisits (Rising et al., 2016). Making an appropriate disposition decision can help providers reduce healthcare costs, increase the older adult's quality of life, and reduce ED visits and revisits (Misch et al., 2014; Schoenfeld, Radecki, & Melnick, 2018; Steinmiller et al., 2015; Zubritsky et al., 2013).

Patient Engagement in Disposition Decisions

A conscientious disposition decision in the ED setting is one that is shared between the provider and the patient (Kraus & Marco, 2016). It is important to include patients' preferences of their disposition decision to achieve successful outcomes for older adults, their caregivers, and the healthcare system (Rising et al., 2016; Vaillancourt et al., 2017). Additionally, understanding how ED patients perceive the disposition decision from the ED will provide pertinent information related to patient reported quality measures (Vaillancourt et al., 2017).

Shortell et al. (2015) conducted a national survey with physicians who are part of an Accountable Care Organizations (ACOs). They focused on how physicians included their patients in the decision making process. The authors identified that physicians recognized the increased need for patient engagement but at the same time found that physicians encountered significant barriers when they attempted to engage their patients with the decision making process. They also identified the following barriers that limit the extent to involve patients with their care decisions: (a) provider workload, (b) provider education about how to converse with patients, (c) time and resources, (d) ED priority management, and (e) communication skills. Shortell et al. implied that the more

patients are included in making their healthcare decisions, the more successful their outcomes.

Adult patients who collaborated with their provider during decision making also had better mental and physical patient outcomes, as shown by Ivey et al.'s (2018) study of 606 adult patients over the age of 18 with comorbidities. Approximately 56% of the patients included in this study were over the age of 65. These investigators found that increasing patient engagement with their treatment plans improved patient satisfaction with increased patient positive outcomes.

Shared decision making can become difficult for the provider when the patient wants to engage in the disposition decision (Katz & Hawley, 2013). Schoenfeld, Goff et al. (2018) surveyed 661 ED patients about their desire to engage in the medical decision making process. They found that most patients wanted a collaborative role with decision making regarding their care. However, most of them would wait to engage actively until the provider included them in the decision making process.

Provider and Nurse Engagement in Disposition Decisions

Dijksterhuis and Van Knippenberg (1998) identified the relationship between how something is perceived, and the action taken in response to that perception. Several studies identified providers' and nurses' perspectives with disposition decisions (Boltz et al., 2013; Bulut et al., 2015; Cadogan et al., 2016; Calder et al., 2015; Dyrstad et al., 2015; Lennox et al., 2018; Steinmiller et al., 2015). Four studies identified a knowledge deficit when caring for the older adult. Bulut et al. (2015), Calder et al. (2015), Cadogan et al. (2016), and Lennox et al. (2018) identified that ED providers and nurses thought

they needed additional education focusing on the geriatric patient. Additionally, based on the results of nine focus groups and seven individual interviews, Lennox et al. (2018) and Bulut et al. (2015) identified that both providers and nurses were overwhelmingly concerned about the need for additional time to facilitate appropriate disposition decisions.

In a systematic review of 25 studies, Steinmiller et al. (2015) examined factors that affect disposition decisions. They found five factors that influence the provider's decision when deciding where to discharge a patient: (a) unresolved issues, (b) the utilization of screening tools, (c) after care instructions, (d) medication prescription, and (e) patient residence. The factors identified in their review indicate the need for individualized care when making the disposition decision from the ED for an older adult.

Dyrstad et al.'s (2015) qualitative study of 27 various healthcare professionals identified evidence of caregiver support as an essential factor when making a disposition decision. The professionals sought older adult patients' perspectives of how much involvement they desired with the decision making process (Dyrstad et al., 2015). One factor identified through the interviews was that the patient's caregiver tends to be demanding during the disposition decision making process. A related issue that Dyrstad et al. identified was the concern that patients might be admitted based on the caregiver's needs and not the patient's needs. Despite the negative factors identified, Dyrstad et al. concluded that healthcare professionals feel it is important to consider the caregivers when determining disposition decisions from the ED because older adults have unique

circumstances that impact the disposition decision and caregivers often know of those unique circumstances.

In contrast to the study of provider factors, the qualitative study by Boltz et al. (2013) considered the perceptions of ED nurses on making the ED environment more conducive for the older adult. Five themes emerged from the data: (a) demonstrating respect for the older adult during an ED visit, (b) using evidence-based procedures, (c) taking time to talk with the older adult, (d) transitioning from the ED to a disposition decision, and (e) having a safe environment. The researchers found that nurses are concerned with unsafe disposition decisions that result in ED revisits and admissions. In addition, the nurses in this study recognized the need to include the older adult in the decision making process.

Studies are warranted to identify if effective communication between the provider and the older adult patient improves disposition decisions as perceived by the patient, patient outcomes, and healthcare costs (Rising et al., 2016). In an integrative literature review conducted by Hutchinson et al. (2019), the authors found ineffective communication regarding the clarity with discharge instructions with older adults increases ED visits and revisit rates. Hastings et al. (2011) found that 24% of older adults returned to the ED within 14 days of their initial discharge due to not understanding the provider's complicated patient discharge instructions.

Comorbidities and Disposition Decisions

Fourteen studies identified that the process of making disposition decisions for older adults with comorbidities is complex and problematic (Biese et al., 2019; Burton et

al., 2014; Castillo et al., 2019; Gabayan et al., 2015; Hwang et al., 2018; McClelland & Sorrell, 2015; Pines et al., 2013; Platts-Mills & Glickman, 2014; Provencher et al., 2015; Salvi et al., 2008; Sharieff et al., 2014; Ukkonen et al., 2019; Vat et al., 2015). Most often, older adult patients who seek treatment in the ED have complex histories revealing one or more comorbidities (Dharmarajan et al., 2017). They are often taking multiple medications to treat their multiple conditions; those factors complicate the disposition decision process because they frequently necessitate additional diagnostics and resources prior to a disposition decision (Pines et al., 2013).

Disposition decisions in the ED are often based on presenting complaints and short-term factors in recovery, but both Burton et al. (2014) and Provencher et al. (2015) found serious problems with using a short-term focus for older patients with chronic comorbidities. Disposition decisions that attend to older patients' recovery from an acute issue may not account for the additional limitations of many older adults, including comorbidities, frailty, and both financial and social burdens (Provencher et al., 2015). McClelland and Sorrell (2015) noted that managing the older adult in the ED is problematic not only due to the high number of comorbidities but also due to older adults' use of multiple pharmacies. Pain related to comorbidities is another reason older adults seek treatment in the ED (Castillo et al., 2019).

In a prospective study conducted over a two-year period with older adults, Provencher et al. (2015) identified that older adults, who more frequently visit the ED with minor injuries, have unique challenges in treatment that make it difficult to decide appropriate disposition decisions. Older adults visit EDs in the U.S. upwards of 4 million

times every year due to injury (Provencher et al., 2015) and have also been found to have higher rates of hospitalization with longer lengths of stay (Misch et al., 2014) as well as higher hospital bills (LaMantia et al., 2016).

Several authors identified the need for some type of intervention to assist when deciding the disposition of the older adult with chronic conditions from the ED (Carpenter et al., 2015; Guttman et al., 2004; Hwang et al., 2018; Latham & Ackroyd-Stolarz, 2014; Sharieff et al., 2014). The following interventions were mentioned: (a) implementing screening tools, (b) having separate geriatric EDs, (c) having geriatric providers available in the ED, and (d) having ED case managers involved with the disposition of the patient.

Latham and Ackroyd-Stolarz (2014) suggested both the implementation of additional programs of care to meet the needs of older adults with chronic comorbidities and the reevaluation of the older adult population to identity those most vulnerable to repeated ED visits. Hwang et al. (2018) identified the need to address the older adult's age-specific needs for appropriate care and patient outcomes. Through a prospective observational cohort study conducted from 2013 to 2015 with 57,287 older adults, these investigators identified the utilization of interventional programs targeting the disposition decisions. They found that programs such as the utilization of a transitional nurse can significantly decrease hospital admissions and ED revisits.

Several studies showed that comorbidities significantly impact disposition decisions, and there is some evidence to suggest a link between comorbidities and hospital revisits. When Vat et al. (2015) studied why patients sought treatment in the ED

within 14 days of discharge from a hospital's medical surgical unit, all eight participants had at least two comorbidities. The results showed that patients sought treatment in the ED due to taking ineffective medications, being discharged too soon, continuing to feel weak, lacking resources, and being unable to understand their discharge instructions (Vat et al., 2015).

Gabayan et al. (2015) found through a retrospective cohort study that almost 5% of older adults with comorbidities who are seen in the ED daily are admitted to the hospital within seven days post ED discharge. The significance of the severity of a patient's comorbidities was not explored in the reviewed studies; however, Salvi et al. (2008) identified that the Cumulative Illness Rating Scale can be useful in identifying the severity of a patient's comorbidities. Vat et al.'s (2015) study differs from Gabayan et al.'s (2015) study because the former's disposition decision occurred from an in-hospital medical-surgical unit rather than an ED. Additionally, Vat et al.'s (2015) study was not specific to older adults, and only eight participants were in the study. Further studies may be needed to examine the importance of comorbidities as a factor in why patients discharged either from the hospital or the ED revisit the ED after discharge.

A retrospective cohort study conducted by Biese et al. (2019) identified "non-white older adult males, Medicaid recipients, recent provider office visit, and multiple hospital admissions and ED visits" (p. 16) as having increased ED return visits. In addition, the authors found that 45% of older adults treated in the ED more than three times within six months continued to seek additional ED treatment, whereas older adults who had a onetime visit had an 18% ED return rate (Biese et al., 2019). The authors

concluded that the ability to recognize high risk patients for ED revisits, hospitalizations or mortality should have an additional process in place for successful disposition decisions, therefore reducing the rate of ED revisits. Recognizing older adults' different needs through the SDM process provides for successful patient outcomes and decreased healthcare costs. In contrast, Biese et al. (2019) identified that older adults who have resolved symptoms after treatment in the ED and have a disposition discharge to home are encouraged to return to the ED for further evaluation if symptoms return as opposed to waiting for an appointment with a provider and risking a possible hospital admission.

Ukkonen et al. (2019) studied a total of 6944 older adults over 2 years. Comparing older adults over 80 to those under 80, the authors identified that those over 80 had three times as many ED visits as those under the age of 80 (Ukkonen et al., 2019). Meeting both the immediate needs and long-term needs related to their additional comorbidities through home nursing visits, and increased community resources and provider support could decrease ED visits and increase positive patient outcomes (Ukkonen et al., 2019).

In summary, these studies revealed that the disposition decision becomes increasingly difficult with older adults with comorbidities; thus, ED providers need to consider older adults' comorbidities when determining those patients' ED disposition decisions (Burton et al., 2014; Gabayan et al., 2015; Hwang et al., 2018; McClelland & Sorrell, 2015; Pines et al., 2013; Platts-Mills & Glickman., 2014; Provencher et al., 2015; Salvi et al., 2008; Sharieff et al., 2014; Vat et al., 2015). Older adults who present to the ED with comorbidities take longer to assess, and the long assessment delays the

disposition decision process (Burton et al., 2014; Gabayan et al., 2015; Hwang et al., 2018; McClelland & Sorrell, 2015; Pines et al., 2013; Platts-Mills & Glickman al., 2014; Provencher et al., 2015; Salvi et al., 2008; Sharieff et al., 2014; Vat et al., 2015). The findings of Carpenter et al. (2015) further substantiate that more time and attention are warranted when making the disposition decision.

Both Capan et al. (2018) and Calder et al. (2015) have argued that there is a gap in the literature on how ED providers decide ED patients' disposition; in other words, the factors that affect how ED providers make disposition decisions are unknown. Understanding the factors that patients perceive as important to the decision making process is also little understood. Research identifying older adults' needs for accurate disposition decisions from the ED is required (Cadogan et al., 2016). It is important to identify factors that affect the disposition decisions from the ED from the perspective of the older adult. Identifying factors that can improve the disposition decisions could provide individualized cost-saving care that will result in positive patient outcomes while lowering Medicare patients' healthcare costs.

Overcrowding and Disposition Decisions

Several authors identified overcrowding as a factor when determining disposition decisions (Chiu et al., 2018; Latham & Ackroyd-Stolarz, 2014; McClelland & Sorrell, 2015; Morley et al., 2018; Perimal-Lewis et al., 2015; Platts-Mills & Glickman, 2014). Salway et al. (2017) defined ED overcrowding as "no space left to meet the timely needs of the next patient requiring emergency care" (p. 214). Overcrowding in EDs is a nationwide problem that can affect patient outcomes (Wallingford et al., 2018). Through

a retrospective study completed in Canada, Latham and Ackroyd-Stolarz (2014) found that ED overcrowding due to hospital bed unavailability increased the stress experienced by ED providers and nurses. Patients in overcrowded EDs are subject to delays in treatment and increased medical errors; increased mortality rates have been linked to overcrowding (Morley et al., 2018). McClelland and Sorrell (2015) identified ED crowding as a factor for poor healthcare outcomes. In another study overcrowding was found to influence the provider's decision to admit a patient to the hospital or observation unit as opposed to taking the time to provide a safe discharge home (Chiu et al., 2018). Perimal-Lewis et al.'s (2015) retrospective study of ED utilization between 2004-2011 identified overcrowding as a factor affecting the disposition decision.

Being an older adult and having comorbidities are associated with overcrowding (Morley et al., 2018; Perimal-Lewis et al., 2015). Perimal-Lewis et al. (2015) suggested that future studies target older adults with comorbidities and their impact with the disposition decision. Morley et al. (2018) found a correlation between overcrowding and older adult care, and they suggested increased research into why older adults continue to revisit the ED. The information provided through these articles indicates that overcrowding significantly impacts disposition decisions from the ED. There is little evidence to suggest what impact overcrowding may have with the older adult's perception and length of engagement with the disposition decision making process.

Health Literacy and Disposition Decisions

Health literacy is an important factor for older patients and their caregivers (Barrett et al., 2016). Health literacy has been identified as a 2030 Healthy People

objective and an important factor for continued research (U.S. Department of Health and Human Services, 2020). Several factors can impact health literacy, including patients' knowledge of their health and their cultural background (Naylor et al., 2013). Five articles focused on the relationship between health literacy and a disposition decision (Barrett et al., 2016; Griffey et al. 2016; Koh et al., 2013; Naylor et al., 2013; Yuen et al., 2018). Koh et al. (2013) identified a health literacy care model to facilitate patient participation with healthcare decisions through shared decision making. If patients do not understand their treatment and disposition decision options then the decision making has failed, even if the provider shared information with them.

Summarizing a 2016 Academic Emergency Medicine Consensus Conference on SDM in the ED, Griffey et al. (2016) identified that utilizing a shared decision making model can increase patients' understanding of the decision being made and help patients with low health literacy to understand their disposition decision. Barrett et al. (2016) also concluded that if shared decision making regarding treatment is to take place, patients need to completely understand the risks and benefits of options related to their treatment plan regardless of their health literacy level.

In summary, the patient's health literacy can affect the disposition decision process (Barrett et al., 2016; Griffey et al., 2016; Koh et al., 2013; Naylor et al., 2013; Yuen et al., 2018). Communication with patients becomes a challenge, especially when there is low literacy in the family (Yuen et al., 2018). Low health literacy was consistently associated with more hospitalizations and greater use of emergency care.

Three-Talk Model of Shared Decision Making (SDM)

When working with the older population, making health care decisions is challenging (Beverly et al., 2014). Increased collaboration and communication between healthcare professionals and the older adult will assist in meeting those challenges (Beverly et al., 2014). Collaboration between the ED provider and the patient and accessing additional resources can make it easier to determine the patient's best discharge disposition. For example, additional resources can include access to a specialty care unit for a few days as opposed to a hospital admission.

The Three-Talk Shared Decision Model (SDM) relates well to this study's focus because it facilitates a joint effort between a provider and the patient when making healthcare decisions that follow best evidence-based practices (Elwyn et al., 2012). The SDM Model was first introduced in 1997 (Hess et al., 2015). Charles et al. (1997) identified important components integrated into the model that would assist with determining accurate discharge dispositions or treatment plans for patients. The components of the model include: (a) provider and patient involvement, (b) both the provider and patient share information regarding the patient's illness, (c) both the provider and patient arrive at a mutual decision for a treatment plan, and (d) implementation of the treatment plan (Charles et al., 1997).

In 2012 Elwyn et al. proposed a shared decision making model to facilitate improved communication and assist with treatment and disposition decisions (Elwyn et al., 2017). Through academic input from different countries, online surveys with patients, and clinician feedback the Three-Talk Shared Decision Making Model evolved for easier

implementation into the clinical setting (Elwyn et al., 2017). The model that emerged includes information sharing, developing mutual trust, comparing different treatment options, and giving the patient a vital role in implementing those options (Elwyn et al., 2017). See Appendix A. These decision making components are enacted through three types of talk between care providers and patients: (a) work together and ask about patient goals (called "team talk"); (b) convey choices after talking with the patient (called "option talk"); and (c) assist the patient with making decisions (called "decision talk"). At the center of the model are deliberations. During deliberations, providers need to repeat the various options if the patient is unsure about certain options (Elwyn et al., 2017). Additionally, Elwyn et al. (2017) identified active listening as a core skill in the process of shared decision making.

One recent study was found to have observed the process of the Three-Talk SDM Model between providers and patients (Williams et al., 2019). Williams et al.'s (2019) study utilized observational techniques to identify the implementation process of the Three-Talk SDM Model between providers and patients. This study observed six key processes they identified as important within the Three-Talk SDM Model (Williams et al., 2019). Overall, Williams et al. identified that the Three-Talk SDM model is more complicated when implementing with different patients. They found that providers may spend shorter time with different parts of the model. In response to the observations, they developed a model derived from the Three-Talk SDM model titled The Implement – SDM model (Williams et al., 2019).

Several studies found to focus on the process of shared decision making within various clinical settings (Ankuda et al., 2014; Burton et al., 2017; Noseworthy et al., 2019; Schoenfeld et al., 2019). Still, little research has identified the implementation of the Three-Talk SDM model in the ED specific to an older adult population. Ankuda et al. (2014) targeted a pre-op population, whereas Burton specifically targeted older women diagnosed with breast cancer. Although different from other studies, Burton et al. (2017) surveyed women who were offered choices regarding diagnostic testing. The authors found most of the women preferred to be involved with their diagnostic testing choices. Noseworthy et al. (2019) specifically focused on the patient in atrial fibrillation and anticoagulant therapy. The authors of this study developed their own shared decision making tool applicable to their cardiovascular population. They found that shared decision making was useful with both patients and providers when facing difficult choices (Noseworthy et al., 2019). Schoenfeld et al. (2019), through the administration of two tools that measure the process of shared decision making (CollaboRATE and the SDM-Q-9), in an ED setting, found fewer than half of the patients surveyed were not involved with the decision making process.

However, there are obstacles to shared decision making. McClelland and Sorrell (2015), Platts-Mills and Glickman (2014), and Salvi et al. (2008) identified comorbidities and overcrowding as factors that can impact the providers' disposition decisions. These factors can impede the shared decision making process, increasing the odds of making inappropriate disposition decisions that can result in adverse patient outcomes. Mishra et al.'s (2018) study identified shared decision making to increase patient engagement, but

also found that providers and nurses had little knowledge about shared decision making and how to effectively implement it. Another barrier recognized by providers is the time it takes to implement shared decision making in an ED setting (Mishra et al., 2018).

The Three-Talk SDM Model can enable older adults to understand their treatment options and provide individualized care that leads to improved patient outcomes (Kunneman et al., 2016). Elwyn et al.'s (2017) Three-Talk SDM Model provides a framework to use when studying older adult engagement in decision making because of its simplicity. Thus, the interview questions for this project have been developed utilizing the Three-Talk SDM Model.

Gaps in the Literature

The literature review indicates multiple factors that can impact the disposition decision from the ED for an older adult. Key factors include comorbidities, overcrowding, low health literacy, limited provider and nurse engagement with the disposition decisions, and limited patient engagement with the disposition decision. In addition, we known effective communication and time constraints significantly impact the implementation of the shared decision making process (Shortell et al., 2015). The disposition decision is important in achieving positive patient outcomes and decreased healthcare costs.

Researchers have identified the negative impacts that inappropriate disposition decisions can have for an older adult. This review suggests that improved disposition decisions are possible through the implementation of communication collaboration between a provider and the older adult patient. Most identified published studies of the

disposition decision making process have been conducted from health team members' viewpoint. We do not know from these studies what perceptions older adults have about their engagement with the decision making process concerning their disposition decision from the ED. Additional qualitative studies are needed to better understand older adult patients' perceptions about the process of shared decision making (Pusey et al., 2019).

The SDM process has been identified as an important factor for older adults regarding their ED care (Schoenfeld et al., 2019). Moreover, additional studies are needed to identify information as to the older adult's perception of their participation in the disposition decision making process from the ED (Schoenfeld et al., 2019). Identifying patient perceptions as to their engagement with the disposition decision will help overcome barriers that patients identify with the shared decision making process.

CHAPTER III

METHODS

This chapter addresses the methodology of the research. The chapter is divided into seven sections: (a) research purpose and questions, (b) research design, (c) setting and sample, (d) data collection, (e) data analysis, (f) trustworthiness and reflexivity, and (g) ethical considerations.

Research Purpose and Questions

This study explored the perceptions and engagement of older adult ED patients as to their disposition decision from the ED. Thus, the following were the set of research questions for this study:

RQ1. What are older adults' perceptions of their direct engagement in the decision making process related to their disposition from the emergency department?

RQ2. How do older adults who present to the emergency department for care perceive the discharge decision making process and disposition decision from the emergency department?

RQ3. What factors do older adults identify as important when making the decision about their disposition from the emergency department?

Research Design

This research study used a descriptive qualitative approach, which is appropriate for collecting narrative data from patients about their experiences of the disposition decision from the ED (Bradshaw et al., 2017). Additionally, qualitative descriptive research utilizes researcher interpretation of the data, allowing the researcher to put together results that closely reflect the data (Sandelowski, 2010). One value of a descriptive qualitative study is to gain information from the participants' own experiences using their own words (Sandelowski, 2010). Though patient perceptions can be quantified through certain survey methodologies, this study's qualitative approach provided in-depth inquiry to better understand older adults' experiences related to discharge from the ED and their appraisal of those experiences (Barker, 2015). Identifying the uniqueness of each participant and complexity of their experience as to their disposition decision from the ED provides insight for how to improve the discharge disposition process.

Setting and Sample

Setting

The initial plan for this study was to recruit study participants from the emergency department of one large acute care hospital in North Carolina. Within weeks of receiving IRB approval for the study, the SARS-associated coronavirus (SARS-CoV-2) pandemic emerged, and this hospital, like those throughout the country, saw a severe drop in ED visits. Due to the pandemic emergency department visits were decreased by 42% (Hartnett et al., 2020). Because of the continued pandemic ED visits continued to

significantly decrease (Hartnett et al., 2020). Additionally, new policies and procedures at hospitals led to a variety of measures to limit contact between patients and those not essential for their care. As a result, recruitment for this project was changed to include additional sites and outreach through social media taking the study from a single site study to a study with multiple recruitment sites. Additional recruitment sites included a second small hospital in North Carolina, a senior center in North Carolina and a church in Pennsylvania.

Sample

A purposive sample of older adults who had been recently discharged from the emergency department were recruited for this study. Purposive sampling was appropriate because it involves selecting participants based on specific criteria to ensure they will be able to provide rich information relevant to answer the research questions (Streubert & Carpenter, 2011). The following inclusion criteria were used to identify potential participants from patients discharged from an ED: (a) over the age of 65, (b) able to read and speak English, (c) received treatment in the ED within the past one to four weeks and (d) were discharged to home, a skilled nursing facility, assisted living placement or observational unit. Exclusion criteria included the following: (a) a dementia diagnosis, (b) individuals under 65 years, (c) unable to communicate, (d) discharge to an acute inpatient unit, and (e) both psychiatric patients and patients enrolled in hospice because the disposition decision for psychiatric and hospice patients can include several additional options that do not pertain to the research questions of this study.

After receiving a call from one participant's daughter whose mother was interested in the study, but only spoke Spanish, my dissertation chair was consulted prior to the decision to proceed with the interview. IRB approval was obtained for a translator prior to the interview.

The number of participants was based on data saturation (i.e., when the information collected is identified as repetitive) (Fusch & Ness, 2015). Data saturation has been known to occur in other similar type qualitative studies with 8-10 patients (Streubert & Carpenter, 2011). Thus, data collection and analysis were concurrent. Due to the SARS-CoV-2 data saturation for this study may not have been completely reached, although there were enough data to identify saturation for some questions.

Recruitment

Recruitment ended up being done through a variety of ways because of the SARS-CoV-2. Recruitment flyers (Appendix B) were distributed to all four settings. At the large hospital, the distribution of the recruitment flyer was overseen by the ED case manager. At the rural hospital, the flyer was placed in a box for ED patients to take if interested. At the senior center, the flyer was posted on their website for older adults to view. At the church, the flyer was placed on both their website and Facebook sites. IRB approval was obtained for each site before displaying the recruitment flyer.

The recruitment flyer provided general information about the study and invited potential participants to contact the researcher by phone if they were interested in learning more about the study. It also informed them that participants in the study would receive a $25 gift card as a token of appreciation for their participation. Additional

recruitment was accomplished through snowball sampling. According to Braun and Clarke (2013), snowball sampling is a strategy commonly utilized to identify participants who are known through previous research participants or those who have been given the flyer from additional participants who have viewed the flyer from the web or Facebook sites.

As potential study participants contacted the investigator by phone the recruitment script was used to explain the study purpose and provided basic information about what participation meant (Appendix C). If persons indicated interest in participating in the study, the Information Sheet was read to them (Appendix D), questions were answered, and verbal consent to participate in the study was obtained. All seven participants agreed to participate in the interview at the time of the initial phone contact. A master list of participants was created as they agreed to participate in the interview; it is retained in a secure location and interview codes were assigned to each patient for data forms, audiotapes, and transcripts. For example, the first interview was coded with the number one. Recruitment was open until the end of 2020.

Data Collection

Procedure

Gaining a better understanding of the older adults' experiences with disposition decision making in the ED by conducting qualitative interviews can provide in-depth information to understand and improve services (Barker, 2015). Therefore, interviews were conducted using an inductive approach capturing the older adult's perceptions and engagement in the ED discharge disposition process. Semi-structured interviews were

performed primarily using open-ended questions. Interview times ranged from approximately 13 minutes to 37 minutes with a mean of 27.6. All of the interviews were conducted within two days of the ED visits. Open-ended questions assisted with developing a comprehensive response from the participant and allowed them to talk about what matters to them most about their disposition decision (Braun & Clarke, 2013). The interviews were conducted via phone from a private location.

Interview Guide

The data collection tool for this study was an investigator-developed interview guide (See Appendix E.). An interview guide was used to ensure that the questions asked during the phone interviews explored patient perceptions and engagement of the disposition decision. Developed based on the Three-Talk SDM model, the questions examined information sharing, comparing treatment options, and assessing patient engagement in the process of their disposition decision (Elwyn et al., 2017). The use of a conceptual framework can be implemented to guide data collection (Sandelowski, 2010). The interview guide included demographic information about health status and health conditions, age and gender, and regular source of care and number of visits to the ED in the past twelve months. Open ended questions were used to explore how participants perceived their involvement in the disposition decision making process. Follow-up questions to further explore topics raised in the participant's response were asked (Taylor et al., 2015). As the last question of the interview, participants were encouraged to share any additional information that may not have been specifically identified in previous interview questions. At the end of the interview, their address was obtained to mail the

$25 gift card to them. The destruction of the participant's address occurred after a receipt of the gift card was received.

Data Analysis

Thematic analysis is appropriate for this research because the aim of the study was to explore subjective perceptions and engagement of older adult ED patients regarding their disposition decision from the ED. Thematic analysis was used to synthesize the descriptions of the participants' experiences and their engagement with the disposition decision making process and develop pertinent themes that produce dynamic connections across codes and transcripts (Vaismoradi et al., 2013). The details extracted from the themes accurately reflected the participants' experience and their engagement of their disposition decision from the emergency department (Castleberry & Nolen, 2018). A systematic step by step approach outlined by Braun and Clarke (2013) was used for the analysis.

Step 1: Data Transcription

Consistent with the process described by Braun and Clarke (2013), in the first phase the data was professionally transcribed. Each transcript was checked line for line for fidelity against the audio recordings.

Step 2: Familiarization of Data

The transcribed data was read and reread to identify and highlight statements that attracted my attention. This procedure allowed me to become fully immersed in the data and develop command of the context of the interviews and the whole of what each participant was saying. Ideas that reoccurred within the data that are unusual, similar, or

different were highlighted utilizing colored highlighters within the MAXQDA 2020 Plus system. MAXQDA 2020 Plus is a software program that is designed to assist with the organizing and analyzing qualitative data (MAXQDA, 2018).

Step 3: Coding

The next step in managing the data was to organize and analyze it using the qualitative software MAXQDA 2020 plus (2018) (Braun & Clarke, 2013). Emergent coding was done through an iterative process. Through iteration linked codes began to emerge to develop into themes (Table 1). MAXQDA 2020 Plus allowed me to organize and visualize the data to see patterns that may not be clearly visible when viewing the transcripts alone, thereby allowing me to determine additional codes. Through MAXQDA 2020 Plus an excel spread sheet was generated that contained pertinent information about each participant's perception and engagement of the disposition decision making process in relation to each question.

Coding was based on inductive methods, examining how participants described their decisional processes; in so doing, the researcher ensured that all coding decisions came from the data (including research notes) and not from a priori notions, and the researcher described dynamic links between codes that elucidated the decision making processes that may be unique to this population in this context. The coding process was then conducted. Peer review by my dissertation chair was conducted through weekly meetings to protect against premature notions of the data and important factors that may have been missed. As the coding process continued to move forward, a more in-depth conceptual interpretive meaning of the data was extracted.

Step 4: Theme Development

Following the coding process reading and rereading of the coded data was done to gain an overall understanding of participants' perspectives about their disposition decision experience. Codes that did not appear suitable to answer the research questions were discarded. The researcher identified meaningful patterns through the data for each of the research questions. Accumulating all the identified codes and narrowing them into related themes through the continuation of reading and rereading the data was completed. Meaningful patterns were identified through the data for each of my research questions. This phase concluded with accumulating all the identified codes and narrowing them into related themes through the continuation of reading and rereading the data. For example, after several readings of the transcribed codes, frustration, anger, and apprehension were identified as patterns that fell under emotional reactions (See Table 1).

To assist with understanding the meaning of each theme, the researcher added original text from the interviews. Following several continuous readings, final definitions of each theme were discussed with my chair. After several themes were identified main themes and subthemes emerged. The Three-Talk SDM model was implemented when considering the participant perspectives of their engagement with their disposition decision and with the analysis of my first research question**.** Additionally, it assisted with contextualizing the findings of this study.

Table 1

Convergence of Themes From Initial Coding to Resultant Theme

Interview Extract	Initial Codes	Resultant Theme
"It was worse, and it never got any better. I immediately called the hospital and felt that was a total waste of time"	Unrelieved pain	Emotion: Frustration
"Well, I went in at 10 and I came out at 10, Unrelieved pain so . . . as far as pain level."	Unrelieved Pain	
"They kept saying, we are here for you; you can come back, but I wanted them to tell me, come back and do what?"	Anger	
"I wasn't functioning positive at all."	Sad	

Trustworthiness and Reflexivity

Multiple factors contributed to the trustworthiness and reflexivity for this study. First, the credibility of the findings was checked using debriefing sessions with the committee chair. Second, the data extracts that are rich in context provided powerful meanings to the disposition decision were included in the analysis (Braun & Clarke, 2013).

A research field notebook was kept for several purposes. It included a decision making audit trail of personal notes to provide a clear description of the research track. The research notebook contained ideas and questions that I wanted to consider further during the data analysis process (Braun & Clarke, 2013). For example, during the

interview and review of the audio recordings emotions could be sensed in the participants' voices, such as one participant's vocal inflections when talking about her unrelieved pain. Also, I was able to identify assumptions or biases by reflecting on the field notes captured during the interviews. For example, in the second interview the researcher reflected on the disposition decision making process from one participant who worked in the ED for several years and its effects on the post discharge treatment outcomes.

Ethical Considerations

Approval from the University of North Carolina at Greensboro (UNCG) IRB was obtained prior to the initiation of the study. As new recruitment settings were added, IRB approval was sought from UNCG. During the proposed study, precautions were taken to protect the privacy of the participants. The participants' identities were kept confidential with the student researcher in a locked cabinet in the student researcher's office. A professional transcriptionist transcribed the digital audio recordings, but the participant's full name was not stated during the interview, so the transcriptionist was not able to identify the participant. For each audiotaped interview and the respective transcript of the interview, the names of specific individuals were replaced with identification codes. The transcriptionist signed a certificate of confidentiality.

The digital audio recording of the interviews and the researcher notebook were kept in a locked cabinet in the researcher's locked room. The master list of the participants' names and addresses was kept in that locked file cabinet in the researcher's locked office. Only the student researcher has a key to that locked file cabinet. The digital

audio recordings were uploaded into UNCG Box, a cloud-based secure storage space, and were accessible only by the researcher and faculty member. The transcriptionist had access during the period the tape recordings were being transcribed to access the audiotapes, then upload the transcribed data into the Box folder. The recordings were kept until the transcription was checked for accuracy and uploaded to the UNCG box. Once they were uploaded to the UNCG Box and verified the interviews were erased from the tape recorder. To destroy audio recordings, they were deleted from the server using ERASER and by shredding data on paper after five years. Identities of individuals were kept confidential with the lead researcher. The name of any provider or staff mentioned during the interview process was replaced with a role. For example, Nurse 1 or Provider 1. Pseudonyms were used when reporting the findings.

CHAPTER IV

FINDINGS

This chapter presents the results of the analysis of the interview data. The first section of this chapter reports the demographics of the participants. Following the demographic data, the next section illustrates the Three-Talk SDM model's concepts and its application to the participants' perceptions of their direct engagement with the discharge decision making process and disposition decision from the emergency department. The third section includes the emergent analysis extracted from the qualitative data, which addresses the older adults' perception of the discharge decision making process and disposition decision from the emergency department.

Participant Characteristics

Seven interviews were conducted through telephone interviews. The median age of the respondents was 71 and ranged from 66 to 82 years of age. Gender representation included three males and four females. Hypertension was identified as the most common comorbidity based on responses from all seven respondents. All respondents reported being treated in the ED. Three respondents reported no additional treatment in the ED during the past year other than the study-related visit, while four respondents received treatment in the ED at least twice in the past year. All seven participants sought regular medical treatment from their primary care provider. Participant demographics are

displayed in Table 2. A summary of individual respondents' reported comorbidities, the reason for ED visits, and disposition decisions are displayed in Table 3.

Table 2

Participant Characteristics (N=7)

Characteristic	*n* (%)
Age in Years	
66	1 (14.3)
67	2 (28.6)
68	1 (14.3)
70	1 (14.3)
80	1 (14.3)
82	1 (14.3)
Sex	
Male	3 (42.9)
Female	4 (57.1)
Treated in ED within the past year (other than the study-related ED visit)	
Yes	4 (57.1)
No	3 (42.9)
Number of times they have been in the ED in the past year	
0	3 (42.9)
2	4 (57.1)
Most common place they seek health care services	
Primary Care Provider (PCP)	7 (100.0)
Other	0 (0.0)
Comorbidities*	
Hypertension	4 (57.1)
Heart Disease	3 (42.9)
Arthritis	3 (42.9)
Diabetes	1 (14.3)

Note. * Percentages do not total 100% because categories are not mutually exclusive.

Table 3

Individual Respondent Summary

Respondents	Reason for ED visit	Comorbidities	Disposition Decision
Mary	"Pain related to diverticulitis attack"	Hypertension Diverticulosis	Home
Martha	"Did not feel right"	Arthritis Trigeminal Neuralgia Hypertension	Observation
Joseph	"Chest pain"	Arthritis Diabetes Chronic Kidney Disease Heart Disease	Observation
Diane	"Cellulitis in my leg"	Heart Disease Hypertension Past Stroke	Home
Michael	"Peripheral vascular problem"	Heart Disease Peripheral Vascular Disease	Home
Sarah	"Leg was so swollen and painful"	Arthritis Chronic High Platelet Count Hypertension History of Three Strokes	Home
John	"Shortness of breath"	Heart Disease Hypertension	Observation

Research Question 1: What Are Older Adults' Perceptions of Their Direct Engagement in the Decision Making Process Related to Their Disposition from the Emergency Department?

Data for the first research question was analyzed using the Three-Talk Shared Decision Making (SDM) model tenets. The three parts of the Three-Talk SDM model are (a) team talk, (b) option talk, and (c) decision talk.

Team Talk

As defined by Elwyn et al. (2017), team talk highlights the need for the provider to communicate choices to the patient when discussing disposition choices. It includes the provider's responsibility to identify patient goals and utilize them when making the disposition decision. During this initial process, the provider should establish a trusting relationship between the provider and the patient before making a disposition decision.

Communicating Goals

The exchange of information between the provider and the patient helps identify patient goals, which is a critical part of the Three-Talk SDM model (Elwyn et al., 2017). All seven of the study participants shared goals and expectations for their care in the ED with the ED provider. Sarah, as indicated by her interpreter, stated her goal would have been to "have them treat the pain." She continued, "I felt that I kept saying, but I'm here because I'm in pain and you can't do anything for my pain." John stated his goal to go back to his vacation home with his family was only acknowledged by the ED physician after a stay in the ED observational unit. He stated, "Can I just go back to the townhouse I was renting for vacation?" Mary indicated, "Bring in someone else to figure out what to do to relieve me of this pain other than topical solutions." Michael, who identified himself as having some healthcare background, expressed that he was "pretty vocal" when expressing what matters most. Although the participant self-identified as being "pretty vocal," the ED did not meet his overall goal. He was discharged from the ED without definitive testing to confirm a diagnosis. He said, "They told me that if it got worse, to come back—come right back to the ER."

Supporting Goals

This step denotes the process of the provider to elicit patient's goals and demonstrate support for those goals (Elwyn et al., 2017). For example, through effective provider and patient communication, patients can express their need to have pain relief before their disposition decision. Several participants spoke about this aspect of their ED visit. Despite the fact the participants had the opportunity to express their goals overall, most did not feel supported with those goals. For instance, Sarah's interpreter indicated that "Sarah didn't feel supported, and she felt that she kept saying, but I'm here because I'm in pain and you can't do anything for my pain." Michael replied, "I'm not sure whether I could so much say that it was support as much as it was, they were just doing their job." John described his experience of not feeling supported by stating, "The emergency room doctor, I think, that's the one that we just didn't see eye to eye, I don't think." In this case, the participant was on vacation in another state and developed shortness of breath in relation to his congestive heart failure. John described his knowledge of his health as he stated, "Yeah, when I get this—it's congestive heart failure is what it was. I knew what was going on."

In contrast, Mary identified a feeling of provider support**.** Mary expressed her feeling of support because the ED staff told her she could come back to the ED. She said, "Well, yes, because they said I could come back." She continued, "They kept saying, we are here for you; you can come back. But I wanted them to tell me, come back and do what?"

Building of Provider/Patient Trust

For this study building, a provider relationship and patient trust is the provider's ability to establish a non-judgmental environment, allowing them to feel comfortable, allowing them to express their goals, thus indicating a trusting relationship with the provider**.** Five out of the seven respondents talked about their relationship with the provider indicating the lack of trust. John who was on vacation in another state, asked the ED provider if he received the medical information about his comorbidity from his home-based hospital. He stated he received the following response,

> No. They are claiming they did not receive anything, and I said, come on, you are in my room right now. I said, here, I've got my cell phone and I got my doctor's number. We will call him personally and you can talk to him on the phone. We can both talk to him; I'll put it on speaker. He [the ED physician] said, no.

Mary described her experience by saying, "She was going to email them and try to figure out as far as giving pain medication, but I never heard anymore from that."

In contrast, Martha and Joseph described having a positive experience indicating the development of a trusting provider-patient relationship. Joseph replied,

> I would have preferred to go home, because the cardioversion was so effective, I felt really good, but with their advice being we needed to keep an eye on it and make sure it holds and doesn't come back to get you, I thought it's probably the best thing to do.

Martha stated, "The doctor who told me what test that they probably will do on me and he wrote them down. I thought that was nice."

Option Talk

The second component of the Three-Talk Shared Decision Making model is "option talk." This process includes the provider and patient comparing alternatives for the disposition decision. Because the patient may not have understood what is important within this step, information is clarified.

Comparing Alternatives

Participants were asked if they were given alternatives for their treatments and disposition decision. All seven of the participants perceived only one option was provided to them when deciding the disposition decision. When describing additional options, Mary stated, "The care provider did not feel [the health problem] would warrant a continued stay within the hospital, so I did not have a choice. I was discharged." She continued, "When they came in with my papers, I knew I was on my way out the door. Did I feel like I should've been? No." Sarah expressed loudly that she didn't "feel like I was involved at all." Michael sounded dejected and his tone became low and quiet as he stated, "Well, essentially, there wasn't anything they could do for my situation at the time in the ER." John said, "They just kind of said, the one doctor who was an ER doctor, he just really wanted to keep me another day."

Regarding the respondents having an opportunity to clarify information given to them during the ED visit, the interpreter for Sarah stated, "She [the provider] clarified why they were letting me go while I was in pain." In response to clarifying additional testing, Martha stated, "Yes. I would ask them, what kind of test are you doing?" Overall,

all seven participants revealed they did not have a choice with the disposition decision. All seven of the participants agreed they had the opportunity to clarify information.

Decision Talk

The third process of the Three-Talk Shared Decision Making model refers to the task of arriving at decisions, reflecting patient preferences, and making a disposition decision mutually agreed upon by both the provider and the patient (Elwyn et al., 2017). Elwyn (2020) recognized that some decisions are weighted heavier than others affecting how much impact the patient may have with the decision making process. For example, a patient who seeks treatment for acute respiratory symptoms will have a smaller chance of weighing in on their treatment and disposition decision than someone who presents with non-acute symptoms.

Arriving at Mutual Decisions

When participants were asked how involved they were with their treatment and disposition decisions, all seven participants identified at some time in the interview that they were not involved with either the disposition decision making process or treatment options. Although there were three participants who agreed to their disposition decision all seven identified not being involved with the disposition decision making process. In response to both treatment and disposition options, Sarah, as indicated by her interpreter, stated she didn't "feel like she was involved at all." Martha, in response to her testing options and disposition decision stated, "No. right, right, right. I mean that is correct. I was not involved." Regarding his medication regime, John stated, "I just was upset with the doctor in the hospital because he took me off one of my pills that is like

my life-saving pill, and I asked him, why would you do that without asking me or my heart doctor?" Additionally, responding to perceived involvement, Joseph stated, "They didn't really say I could not leave, but I heard if I turned down their care, it might affect my insurance too, so I just did what they said." Mary simply stated, "I wasn't."

The following quotes from Sarah, as indicated by her interpreter, represent the breakdown in all elements of the Three-Talk SDM model. The following represents team talk: "Because it's not a clot, we're just going to send you home. You're going to follow up with your primary [care provider], and then he will refer you to an orthopedic surgeon." An example of option talk was noted when the patient stated, "No other option was presented other than, you're going home and following up. That was the only option. The only option was discharge." When asked about the choice she preferred and representing the decision part of the SDM model, the Sarah's daughter said she would have liked to have been "seen by an orthopedist or an orthopedic surgeon." Additionally, she stated she "would have liked to have had a steroid injection to her knee or have them address the pain in some way, shape, or form."

Another example of an interview identifying the breakdown of all Three-Talk SDM model elements was from Mary, who presented to the ED for pain control related to her previously diagnosed diverticulitis. Representing team talk concerning repeated tests completed, the Mary stated, "I came in at ten, I [was] hurting, so blood pressure is still high, so what did we accomplish here?" Representing option talk, Mary stated, "I understood it, I just didn't—it wasn't acceptable, but I didn't have a choice." In response to decision talk concerning repetitive testing, she stated that she told the nurse, "I've

already been cleared of those things a month ago," and the nurse replied that "you never know when things change."

Table 4

Examples of Key Findings of the Three-Talk Shared Decision Making Model[*]

Key Process	Description of Model	Patient Narrative Data
Team Talk	Communicating Goals	"Bring in someone else to figure out what to do to relieve me of this pain other than topical solutions." (Mary)
	Supporting Goals	"No, I did not feel supported by him at all" (John)
	Building Provider/Patient Relationship	"No. They are claiming they did not receive anything, and I says, come on, you are in my room right now, I says here, I've got my cell phone and I got my doctor's number." (John)
		"The doctor who told me what test that they probably will do on me and he wrote them down. I thought that was nice" (Martha)
Option Talk	Comparing Alternatives	"The care provider did not feel [the health problem] would warrant a continued stay within the hospital, so I did not have a choice. I was discharged." (Mary)
		"When they came in with my papers, I knew I was on my way out the door. Did I feel like I should've been? No." (Mary)
		"She doesn't feel like she was involved at all," as explained by her daughter who translated the interview. (Sarah)
Decision Talk	Arriving at Mutual Decisions	"He took me off of one of my pills that is like my life-saving pill, and I asked him, why would you do that without asking me or my heart doctor." (John)

Note. [*] Adapted from Elwyn et al. (2017).

Summary

The Three-Talk SDM model requires collaboration through interactive communication, providing both parties opportunities to identify specific goals and establish a mutual disposition decision through team talk. Overall, the respondent narratives did not reflect working together as a team to arrive at a mutual disposition decision. Furthermore, the interviews showed a lack of communication between the provider and the participant, which eliminated working together to arrive at a mutual disposition decision. The lack of teamwork also left a communication gap and discouraged the older patient's full participation in the disposition decision.

Overall, the participants perceived they received little support from the provider when it came time to identify what mattered to them most. Although some interviews reflected the exchange of information regarding the participants' goals before the disposition decision, the participants identified a lack of support when communicating what mattered most to them when the provider was making the disposition decision.

Research Question 2: How Do Older Adults Who Present to the Emergency Department for Care Perceive the Discharge Decision Making Process and Disposition Decision From the Emergency Department?

Theme 1: Emotional Reactions

Emotional reactions include the respondent's feelings towards the provider. It consists of the respondent's feelings about their involvement in their treatment and disposition decision making process and acknowledging the provider's feelings towards the participant. Primary subthemes for emotions included frustration, level of comfort, fear or apprehension, and satisfaction level.

Subtheme: Frustration

Frustration includes the older adult's response to decision making process with their treatment and disposition decision. Five out of the seven participants identified a level of frustration with either the treatment or disposition decision. For example, Sarah stated she "was there from around 5:00 p.m. to 11:00 p.m., for six hours, and they didn't do anything" (as indicated by her interpreter). She continued by saying, "It would have been better if I hadn't even gone because they didn't do anything." During the interview, her daughter who was interpreting the interview, noting the participant's evident frustration, attempted to calm Sarah who became increasingly vocal and began talking very quickly. John felt he was badgered by the healthcare provider who repeatedly asked about his living will. John stated, "I have never had a doctor ever ask me that much about a living will." During this part of the interview, John's voice became louder. In contrast, two participants indicated no sense of frustration with their disposition decision. Diane said, "I drove yourself over there and I didn't think that I needed to stay." Joseph stated, "Overall, in the emergency room, it was a pleasant visit."

Subtheme: Level of Comfort

Level of comfort denotes what the participants perceived as a sense of reassurance from the ED provider regarding their disposition decision and treatment conversations. The data indicated that there were times when most of the respondents expressed a sense of comfort with the care provided by the ED physician but later felt uncomfortable with a conversation. For example, Mary stated she was comfortable when they gave her a blanket, proper pillows, and "after they had given me something to drink." Later, the

same respondent stated, “They said I could go to the larger hospital, which is an hour away and more money. That part I was very uncomfortable with.” Sarah indicated she was comfortable with “the fact that they did the labs, and she knew that it wasn’t a clot” (Interpreter). But she was uncomfortable with the visit overall because her pain was not addressed during the ED stay. During the interview with Michael, the older adult identified his discomfort when he stated, “I was a little concerned that it would—you know, further degrade, my condition worsened. But they did say that if anything happened or if I noticed any purpleness, numbness, greyish, whatever discoloration, to come back to the ER.” He further identified a feeling of comfort when he stated, “They confirmed there was a pulse.”

Two respondents, in contrast to the others, indicated comfort with their treatment and disposition decisions. Diane, who expressed a comfortable feeling with the ED visit, previously worked in the ED she visited, which may have contributed to biased feelings towards the ED staff. She stated, “I worked in the same emergency room, you know, the same hospital emergency room for about 12 years.” She continued by saying, “All the people there was very good to me.” Overall, most of the interviews indicated a level of feeling uncomfortable with either their treatment or disposition decision during their ED experience.

Subtheme: Fear

This subtheme involved patients’ concerns about possible complications following their disposition decision. In the transcribed data five out of the seven participants expressed a feeling of fear with either their treatment decisions or with

unresolved symptoms. For example, Michael indicated his fear when he stated, “I was concerned whether the condition would get worse and that I didn’t want to lose a toe or a foot due to whatever this situation.” Mary expressed anger as her voice volume increased, stating that she “left with an elevated blood pressure” and “I left hurting as much as when I went in.” She continued with the interview stating, “I’m sure I’m hyperventilating; I’m hurting so bad, so I’m stressed.” Martha indicated a fear of not feeling “normal” when she left the ED. As she was walking to her car after her disposition decision she stated, “So you feel like blah just because you’re walking from the car.” She continued, “I don’t think that is normal.” Diane, the former ED employee who worked in the same ED she visited, and Joseph were the only two respondents who displayed no sense of apprehension or fear during or after their visit. Furthermore, Diane had been treated in the ED one week before the current study-related visit, which could have contributed to her perceptions of no feelings of fear and apprehension. Joseph identified his multiple visits to the ED for the same problem, which may have contributed to a lack of fear.

Subtheme: Satisfaction Level

Level of satisfaction includes the participant’s perception of the disposition decision and treatment received (Manzoor et al., 2019). Two of the interviewees revealed satisfaction with both their treatment and the disposition decision. For example, Joseph stated, “I love our hospital here and our emergency department is excellent, and our staff is excellent. Like I say, I’ve been there many times and they are always good. I’ve had one negative experience, but that was some time ago. Diane, who previously worked in

the ED where she was treated, stated, “They were very good, and I couldn’t ask for nobody being no better.”

In contrast, dissatisfaction with treatment was identified by five of the older adults. One example was the response Michael who stated, “I wasn’t necessarily happy with the end result.” For instance, when John was asked about his living will, he stated he recognized the arrogance when the provider told him, “I won’t hit you with any paddles.” He further stated, “I’m not worried about that; I’ve got built-in paddles. He was kind of arrogant.” Five of the participants indicated a level of dissatisfaction with either their treatment or disposition decision, with two participants indicating a higher level of satisfaction.

Theme 2: Helplessness

Helplessness denotes participants’ perceptions of their disposition decision with unresolved issues. The participants expressed how these impacted other aspects of their life. Mary stated, “It was affecting everything—my attitude, my sleep, everything. I wasn’t functioning positive at all.” As Martha talked about when she went home, she stated, I didn’t like how I was feeling. I feel like I felt the same way that I went in.” She continued, “I had hope there, but it went out the door by the time I got home.”

In contrast, Diane stated, “Because I drove myself over there and I didn’t think that I needed to stay.” Joseph simply stated, “I felt really good.” Both Joseph and Diane had definitive diagnoses in the ED which may have contributed to the lack of helplessness upon their disposition decision. Overall, most of the respondents indicated a

sense of helplessness due to the lack of a definitive diagnosis or symptom relief affecting everyday activities of daily living.

Theme 3: Provider Empathy

A third major theme included respondents' perceptions of the providers' thoughtfulness or thoughtlessness. Empathy also consists of the providers' ability to understand the participant's frustration with the lack of diagnosis and the disposition decision. Overall, participants' perceptions of how well the ED provider demonstrated empathy was equivocal; sometimes they perceived empathy, other times they did not.

Mary identified the provider's empathy by saying, "She apologized for not being able to diagnose anything." Martha stated, "I said, can I eat something? I need something. And by then, it was after 5:00. And he [physician assistant] went and got me crackers, pudding, Jell-O, and something to drink." Both represented the respondent's perception of the provider's display of thoughtfulness.

In contrast, Sarah stated, using a translator, "I was there because I couldn't walk, it hurt so badly, and they said, there's nothing we can do." She continued by saying, "I was just told to leave and was on my own to follow up." In this case, Sarah's age, the fact that she lives alone, and the 1:00 a.m. discharge time could be interpreted as a lack of empathy on the part of the ED staff and could negatively affect the patient's future ED visits.

Summary

Three primary themes emerged: emotional reactions, helplessness, and provider empathy. The results provided insight into the participants' emotional perceptions of their

ED visit**.** Identifying possible challenges faced by the participants before a disposition decision is made may help to improve patient outcomes.

Research Question 3: What Factors Do Older Adults Identify as Important When Making the Decision About Their Disposition From the Emergency Department?

The third research question identified factors most important to the participants before a disposition decision is made. Although seven participants have different diagnoses and goals from their ED visit, three emergent factors that were important to them were identified: pain, definitive diagnosis, and safety.

Pain

In this study several of the participants sought treatment from the ED because of their pain. Two participants stand out because their pain was identified as high and unrelieved. Some participants identified the pain as severe or a 10 on the pain scale. Two of the seven participants were discharged in pain, both identified their pain as a 10 on a scale of one to ten. Mary stated, “I went in at 10 and I came out at 10.” She continued, “It was affecting everything—my attitude, my sleep, everything. I wasn’t functioning positive at all.” Sarah stated, “She kept saying, 10, and it was maximum. If she could go over 10, she would have, because the pain was so severe” (as relayed by the interpreter).

Definitive Diagnosis

For this study diagnostic testing referred to the ability to have a test done to identify a definitive diagnosis. All the participants identified the ability or inability to receive diagnostic testing in the ED. Four of the participants left the ED without a definitive diagnosis related to the ED’s inability to provide additional testing. For instance, Sarah, as indicated by her interpreter, stated, “She would have liked for them . .

. she would have liked to have been seen by an orthopedist or an orthopedic surgeon. She would have liked to have had a steroid injection to her knee or have them address the pain in some way, shape, or form." Regarding the ED's inability to perform a doppler ultrasound, Michael stated, "There was no further treatment they could provide for me in my situation without this test. So that's why I was just asking if they could do it then and there." Diane indicated she was expecting a diagnosis of cellulitis before the ED visit. Two of the participants who sought treatment from the ED had a definitive diagnosis prior to their disposition decision. One participant had relief of his acute symptoms related to his comorbidity. The remining four participants had no definitive diagnosis prior to their disposition decision.

Safety

The analysis identified safety as important in only one of the interviews, yet it is critical to mention because safety emerged in three additional participants' interviews. Martha noted the ED's concern regarding patient safety at time of discharge. She stated, "They asked me, do I live alone and all that kind of stuff."

In contrast, Mary indicated how the disposition decision prompted additional safety concerns due to her pain and how it affected her everyday lifestyle. Mary identified that when discharged home, "It was affecting everything—my attitude, sleep, and everything. I wasn't functioning positive at all. I just was moping." Diane, who was diagnosed with cellulitis of the leg, stated that she was on a diuretic and stated, "Well, when I got to go, I got to go to the bathroom." She added that she had been issued a walker due to her balance problem. There were comorbidities for which this older adult

was aware. However, the lack of shared decision making limited the conversation and collaboration between the provider and the patient. In that case, the provider may have suggested additional resources or an alternative disposition decision such as short-term rehabilitation in a skilled nursing facility.

Additionally, John identified his concern for his safety when taken off a specific medication. He expressed his concerns to the ED provider and the fact that he could potentially have another heart attack if he went off the medication. The provider discontinued the medication without John's knowledge. Thus, these three study participants identified the provider's lack of communication and sharing of information.

CHAPTER V

DISCUSSION

Previous literature findings have determined that older adult ED visits and revisits will continue to rise as the population over 65 years of age expands, directly impacting healthcare costs (Castillo et al., 2019). Older adults who seek treatment from the ED come with multiple comorbidities, making the ED disposition decision increasingly challenging (Greenwald et al., 2016; Lafortune et al., 2015). Repeated ED utilization by the older adult is associated with negative patient outcomes (Dermody et al., 2017**)**.

Limited research exists regarding older adults' perspectives of their engagement in the disposition decision making process in the ED. Previous studies have identified perceptions from a provider's or nurse's viewpoint of the disposition decision (Boltz et al., 2013; Bulut et al., 2015; Cadogan et al., 2016; Calder et al., 2015; Dyrstad et al., 2015; Lennox et al. 2018; Steinmiller et al., 2015). This study provides additional context to the literature by including the older adult's perception of the process of shared decision making.

Using a qualitative descriptive approach, the researcher explored the older adult's perception of ED disposition decisions, engagement in the decision making process, and factors older adults perceived as important during the process. The Three-Talk Shared Decision Making Model was used as a contextual framework to appropriately guide the study's interview questions and analysis.

Sample

The sample consisted of seven older adults with ages ranging from 66 to 82 years. Although the sample was small, emergent themes identified in the narratives reflected that most of these patients had negative experiences in the ED. Five of the seven participants reported negative experiences in the ED. Two of the respondents who reported overall positive experiences where either a previous employee of the ED they visited or a repeat user of the ED for treatment with his comorbidity. If patient-centered care is truly the primary focus of our healthcare system, the findings of this study are clinically meaningful and affirm the need for improved interventions, awareness, and reflections by health professionals working with older adults in the ED.

The seven participants in this study all revealed at least one comorbidity consistent with recent literature identifying older adults with multiple comorbidities (Dharmarajan et al., 2017). They identified the same most common comorbidities as revealed in the Administration of Community Living Profile for Older Adults (Administration for Community Living, 2020). These included heart failure, diabetes, arthritis, and hypertension.

Key findings of this study revealed that the Three-Talk SDM model's key processes were perceived by these participations to be missing when interacting with their ED provider. Although participants had the opportunity to identify and communicate their goals before a disposition decision, they believed the provider did not acknowledge or support those goals, consequently hindering the development of a provider-patient relationship. The participants perceived they had little input with the

disposition or treatment decisions indicating a breakdown in the Three-Talk SDM model. Nevertheless**,** the seven respondents identified a willingness to participate with their treatment and disposition decisions.

Key findings related to participants' perceptions of the disposition decision making process identified the following emergent themes: emotional reactions, helplessness, and provider empathy. Safety, receiving a definitive diagnosis, and pain were identified as important factors during a disposition. The finding not found in recent literature is that older adults expect a definitive diagnosis when seeking treatment from the ED.

Research Question 1: What Are Older Adults' Perceptions of Their Direct Engagement in the Decision Making Process Related to Their Disposition from the Emergency Department?

Team Talk

Communicating Goals

One of the essential parts of the Three-Talk SDM Model is the process of interactive communication between the provider and the patient to establish the groundwork for a trusting relationship. The provider plays an important role by actively listening and deliberating before making treatment and disposition decisions.

All of the participants identified the opportunity to communicate their goals and expectations with the ED provider identifying the implementation of the first part of the shared decision making process. This finding supported recent studies indicating the importance of identifying patient goals as a beginning step in the Three-Talk SDM Model (Ivey et al., 2018; Shortell et al., 2015; Williams et al., 2019).

The Three-Talk SDM Model provides the patient an opportunity to identify their own goals and expectations when seeking treatment in the ED. These goals can impact the decision making process (Elwyn & Vermunt, 2020). For example, goal-oriented disposition decisions can include the diagnosis process, pain relief, or discharge following the alleviation of any acute symptoms related to comorbidities.

Supporting Goals

The literature supports the acknowledgment of patient goals by the provider, but little research focuses on the process of supporting those goals (Burton et al., 2017; Noseworthy et al., 2019). These findings identified participant perspectives on the support received when communicating goals. Mixed responses were noted from the participants when asked about provider support with their goals. One participant recalled he thought the providers were "just doing their job."

Building of Provider/Patient Trust

A key component with the Three-Talk SDM model is provider trust (Elwyn et al., 2017). Provider trust reflects the older adult's perceptions of feeling supported when expressing their goals in the ED. The need to have a feeling of support while expressing goals is critical in setting the stage for a collaborative disposition decision. Working together to build a trusting relationship and arrive at a mutual disposition decision between the provider and the patient is an important part of patient-centered care.

Conversely, this study revealed that in this sample there was a lack of working together and an absence of established provider-patient relationships. Most of these respondents suggested that providers did not establish a trusting relationship during the

ED visit. It appears that five out seven participants perceived having little opportunity to collaborate in their disposition or treatment decisions.

Overall, the sharing of goals and support needed to implement these goals was not evident in the respondent narratives, a critical piece in forming a provider-patient trusting relationship. Like other research, this study identified the awareness of the patient's view of the provider as an authoritative figure (Schoenfeld, Goff et al., 2018) and the importance of a provider-patient trusting relationship.

Option Talk

Comparing Alternatives

Reflecting on patient-centered care, option talk allows the provider to clarify additional information for the older adult. Overall, this study reflected that all seven of the participants were only given one option. Most participants identified their dissatisfaction with their option, but believed they had no recourse except to comply with the provider's decision. Recent studies support the importance of providing patients with choices when making a treatment or disposition decision (Kraus & Marco, 2016; Rising et al., 2016; Vaillancourt et al., 2017).

Decision Talk

Arriving at Mutual Decisions

The data generated in this study does not reflect shared decision making with older adults in the ED setting. The narratives recorded suggest a lack of patient-centered care with the older adult. Additionally, in some cases, these narratives paint a concerning picture of provider power over the older adult during a vulnerable period in their lives.

Participants believed they had little choice when it came time for the disposition decisions, leaving gaps in their overall well-being and future.

Quotes extracted from the narrative data represented the participants' beliefs that the disposition decision was not made as a collaborative discussion between the care provider and the patient. Participants perceived that only one option was provided to them, thus eliminating the process of comparing alternatives and arriving at a mutual disposition decision.

Previous qualitative studies focus on provider perceptions and the lack of patient engagement with shared decision making. This study found that all seven participants expressed the desire to be involved with their treatment or disposition decision. One participant, for example, revealed his dissatisfaction with the discontinuation of his vital medication.

As found in recent literature (Ankuda et al., 2014; Burton et al., 2017; Schoenfeld et al., 2019), this study also identified a breakdown with the shared decision making process. While much research can be found examining the shared decision making process, this study focused on implementing the Three-Talk SDM Model with an older adult population in the ED.

Research Question 2: How Do Older Adults Who Present to the Emergency Department for Care Perceive the Discharge Decision Making Process and Disposition Decision from the Emergency Department?

Following a complete thematic analysis of the narrative data, three themes emerged: emotional reactions, helplessness, and provider empathy. In addition, emotional

reactions included four primary subthemes: frustration, level of comfort**,** sense of fear or apprehension, and level of satisfaction.

Emotional Reactions

In this study, emotions captured a wide range of emotional responses during the participants' ED experience. Recent literature suggests that positive and negative emotional reactions can impact the decision making process (Isbell et al., 2020). Emotional reactions reflect the participant's emotions towards the provider.

Frustration

In this study both anger and frustration were identified as emotions that may impact the decision making process. Five out of the seven participants identified common experiences of frustration with either a treatment or disposition decision. This could be a result of having visited the ED during the pandemic. For example, one participant identified his frustration regarding the provider's multiple questions about his living will. The data revealed a level of frustration that reflected participants' perceptions of not being heard. Another example involved both the participant and the interpreter. The participant identified frustration due to the lack of pain relief and the interpreter who was frustrated with her mother's lack of pain relief.

Many of the participants perceived frustration with the provider related to the uncertainty of not having a definitive diagnosis prior to the disposition decision. Also, leaving the ED with continued pain or uncertainty regarding worsening symptoms and the potential need for more extensive treatment were causes for participant frustration.

However, little research has been conducted related to frustration and a disposition or treatment decision with older adults.

Level of Comfort

Developing a comfort level is an essential part of the older adults' visit to the ED. Overall, participants identified both a level of comfort and uncomfortableness throughout their ED visit. One participant perceived ease when the provider implemented basic care measures such as offering a pillow or giving her something to drink. But at other times, she was uncomfortable with the provider when she suggested she seek treatment at another hospital. Another participant felt uncomfortable when the ED provider removed his prescribed medication without informing him of the decision. Few qualitative studies focus on what factors impact a level of comfort for patients (Fisher et al., 2019). Fisher et al. (2019) did identify a lack of comfort during patient hospital stays, resulting in hesitancy when voicing additional needs or concerns.

Sense of Fear

Repetitive use of the word fear or expressions of being afraid were noted in the interviews. Overall, five of the seven participants expressed a sense of fear with unresolved or worsening symptoms after the disposition decision was made. Older adults may relate fear to undiagnosed symptoms or fear of dying. Older adults may also view fear differently than patients who are engaged and have a voice in their disposition decision, receive a definitive diagnosis, and have resolved symptoms. Like Rising et al. (2016) and Vaillancourt et al. (2017), this study found fear was a factor when seeking

treatment from the ED. Specifically, Rising et al. (2016) found patients expressed fear related to unrelieved symptoms or general false reassurance upon discharge from the ED.

Level of Satisfaction

Overall, many of these participants were unsatisfied with their disposition or treatment decision. However, participants who were familiar with the ED due to previous employment in the ED setting or who had a history of frequent visits for the same condition identified a level of satisfaction with their treatment and disposition decision. Hughes et al. (2018) recognized that the process of shared decision making positively impacts patient satisfaction and positive patient outcomes.

Helplessness

Identified as the second theme, the narratives revealed helplessness in the participants' perception of unresolved issues. Participants felt there was nothing they could do after the disposition decision or treatment decision was made. Although patients seek treatment from the ED expecting a definitive diagnosis. Four of the participants' responses revealed that they did not get a definitive diagnosis or relief of symptoms, leaving them with a sense of helplessness.

Provider Empathy

A third theme included the respondents' perceptions of the providers' inability to understand the participants' feelings regarding their treatment or disposition decisions. Empathy was linked to the participants' perceptions of the providers' understanding of their situation and the barriers that prevented a successful disposition decision.

Overall, the participants identified the providers' lack of understanding with their disposition and treatment decisions. Participants noted that on some occasions, the provider acknowledged the inability to articulate a definitive diagnosis. The findings indicate that the participants perceived receiving empathy from their provider at some time during their visit and at other times felt the provider did not provide empathy.

Research Question 3: What Factors Do Older Adults Identify as Important When Making the Decision About Their Disposition from the Emergency Department?

Older adults who present with chronic conditions make the decision making process even more vital and complex (Boyd et al., 2019). All participants had at least one comorbidity that could have impacted the disposition decision if acknowledged by the provider. For example, Diane who was satisfied with her treatment and disposition decision later identified in the interview that she had a balance problem. She stated, "My balance is not good." Diane lives alone and has a history of previous strokes affecting her balance. These factors and her recent diagnosis of lower extremity cellulitis could be detrimental to her well-being and result in future ED visits.

This research study did not focus on observational units and the participants' perceptions, yet there were three participants admitted to an observational unit. Literature shows that ED observational units are growing in popularity with older adults (Powell et al., 2020). As this popularity continues and the number of older adult ED visits increase, it is important to note that observational stays may have a greater financial impact on Medicare patients. Under Medicare, observational stays are billed differently than hospital admissions, resulting in higher out-of-pocket costs for the patient (Powell et al., 2020). Providing options includes recognizing the high cost of an ED observational unit.

Safety

This study did not focus on safety, but safety emerged as a common factor within three participant narratives**.** The providers' communication may not have indicated to the older adult that the provider was taking action or showing concern about the older adult's safety. Only one participant acknowledged that the healthcare team recognized risk of falls while in the observation unit, but several participants were identified as having risk factors for falls. Additional safety concerns involved an ED provider who removed a participant's prescribed medication without the participant's knowledge or permission. The participant informed the provider that his primary care provider instructed him never to miss a medicine dose as it could cause a ventricular arrhythmia. The ED provider did not acknowledge the participant's input and took him off his medication without informing him. One participant identified her increased depression and elevated blood pressure after her disposition decision related to her unrelieved pain and undiagnosed symptoms. Greenberg (2020) discovered that one in every three older adults suffered at least one fall per year. Accordingly, Shankar et al. (2017) identified the need to implement actions to prevent older adult falls before a disposition decision in the ED setting.

Definitive Diagnosis

All participants identified having a definitive diagnosis before a disposition decision as an essential factor. According to Rising et al. (2016), patients enter the ED with the expectation of finding a definitive diagnosis before the disposition decision. Four participants in this study also expected the ED to provide additional diagnostic

testing to determine a definitive diagnosis. The results highlight the challenges faced by both the provider and the patient when implementing a shared decision making process.

Molica et al. (2020) found that patients are fearful of undiagnosed signs and symptoms. The most recent SARS-CoV-2 pandemic accentuates the importance of having a diagnosis to offset increased patient anxiety (Molica et al., 2020). Similarly, the same may be true for all diagnoses and increased anxiety for any unresolved issue. This study's findings concur with previous research highlighting a resolution for a definitive diagnosis (Molica et al., 2020).

Pain

Pain management in older adults is complex, especially in the ED. This study revealed several participants who experienced pain or discomfort that was poorly managed. The mismanagement of pain or discomfort as perceived by three older adults in this study reinforces the findings in current literature which emphasize the importance of effective pain management with older adults in the ED (Gorawara-Bhat et al., 2017; Mura et al., 2017). Mura et al. (2017) found pain to be a common factor associated with ED visits. In a qualitative study conducted by Gorawara-Bhat et al. (2017), the authors found pain management was quite the challenge with the older adult. Likewise, this study's findings support current literature regarding the challenges ED environments face with pain management when treating older adults (Gorawara-Bhat et al., 2017).

Limitations

Although participant sampling was small, recruitment measures were creative and persistent. Facilities utilized included two emergency departments, one community

website, and one church website. Due to the pandemic, older adult ED visits declined by 42% between March 2019 to April 2020 (Hartnett et al., 2020). The study utilized snowball sampling to increase the sample size. The advantages of using snowballing sampling added a more diverse range of participants—for example, the ability to include a non-English speaking participant. Also, multiple ways of recruiting a wider participant pool from several areas of the Southeastern part of the United States. Participants were selected based on specific inclusion criteria and cannot be generalized to all older adults in the U.S. Although additional measures were implemented to increase the sample size, the number of participants remained small and may not have been large enough to capture other themes.

The study allowed a one to four week time frame from the ED visit to the time of the interview, so the potential risk of recall bias or omission of some details of the participants' ED visits may have occurred. The narrative data was limited to the patient perspective. This provided a one-sided view of the provider and patient discussion of treatment and disposition decisions.

Finally, one interview utilized the participant's daughter as an interpreter. Although the interpreter is a nurse and was provided with careful instruction regarding the research, personal bias may have played a factor in the accuracy of the interpretation. A debriefing session was held after the interview allowing the participant to vocalize her frustration.

Future Research

Future research should address the provider's empowerment with the disposition decision and how the older adult may perceive this empowerment. Future research is needed to evaluate patient perceptions of the ED disposition decision compared to providers' perceptions. Future research should address additional skills and strategies essential for ED settings to assist with shared decision making with older adults. Because older adults often present to the ED with a primary caregiver, future research should focus on perceptions of the discharge decision making from both the caregiver and the older adult. Also, to abide by the Institute of Medicine (IOM) standards concerning patient-centered care implementation, additional research should be conducted to determine the most efficient process for implementing shared decision making in the ED. Furthermore, a larger sample size could provide data that generates additional codes and patterns that develop into emergent themes impacting the disposition decision.

The addition of quantitative studies may identify environmental factors such as the effects of overcrowding on a disposition decision. These factors may negatively affect time with the patient and the quality of the provider-patient interaction. Systemic and structural issues related to provider inexperience with older adults and use of case managers in an emergency department setting could also positively impact the decision making process.

Implications for Nursing Practice

Although the sample size of this study was small, the older adults received treatment at different ED settings. All seven participants identified that only one option

was provided to them with their disposition decision. This finding is clinically meaningful information that suggests the need for nurses to advocate for inclusion of older adults in shared decision making conversations. An alternative might be providing additional resources such as ED nurse case managers to advocate for older adults with their treatment and disposition decisions. Participating in interprofessional role-playing to improve team, option and decision talk are vital parts of the Three-Talk SDM model. This education and understanding play a crucial role in transforming healthcare delivery focused on patient-centered care to a vulnerable population. If providers have a better understanding about and use of option talk it would assist the older adult in understanding reasonable expectation with treatments and options within an ED setting.

Conclusion

This study identified the lack of operation with the Three-Talk SDM model within an older adult population. The narrative data did not support the Three-Talk model concepts, reflecting the lack of patient-centered care. This study's findings provide valuable information from a patient perspective regarding engagement with the decision making process within an ED setting. Additionally, the findings suggest to ED providers opportunities to put the SDM model into action, thereby creating more effective provider and older adult relationships and an increase in positive patient outcomes and subsequently fewer ED visits.

While this study included a small sample size, themes were identified among the participants' responses. The emergent themes also underscore the many gaps and the need to pay attention to patient-centered care. If patient-centered care is truly the primary

focus of our healthcare system, the findings affirm the need for improved interventions, awareness, and reflections.

This study's results give insight to the older adults' perceptions of their interactions with ED providers with a small group of participants during a pandemic. The outcome of this study provides a detailed breakdown of the components of the Three-Talk SDM model and how one sample of older adults perceive the interactions with ED providers identifying areas for improvement. In return, successful patient-centered care is delivered.

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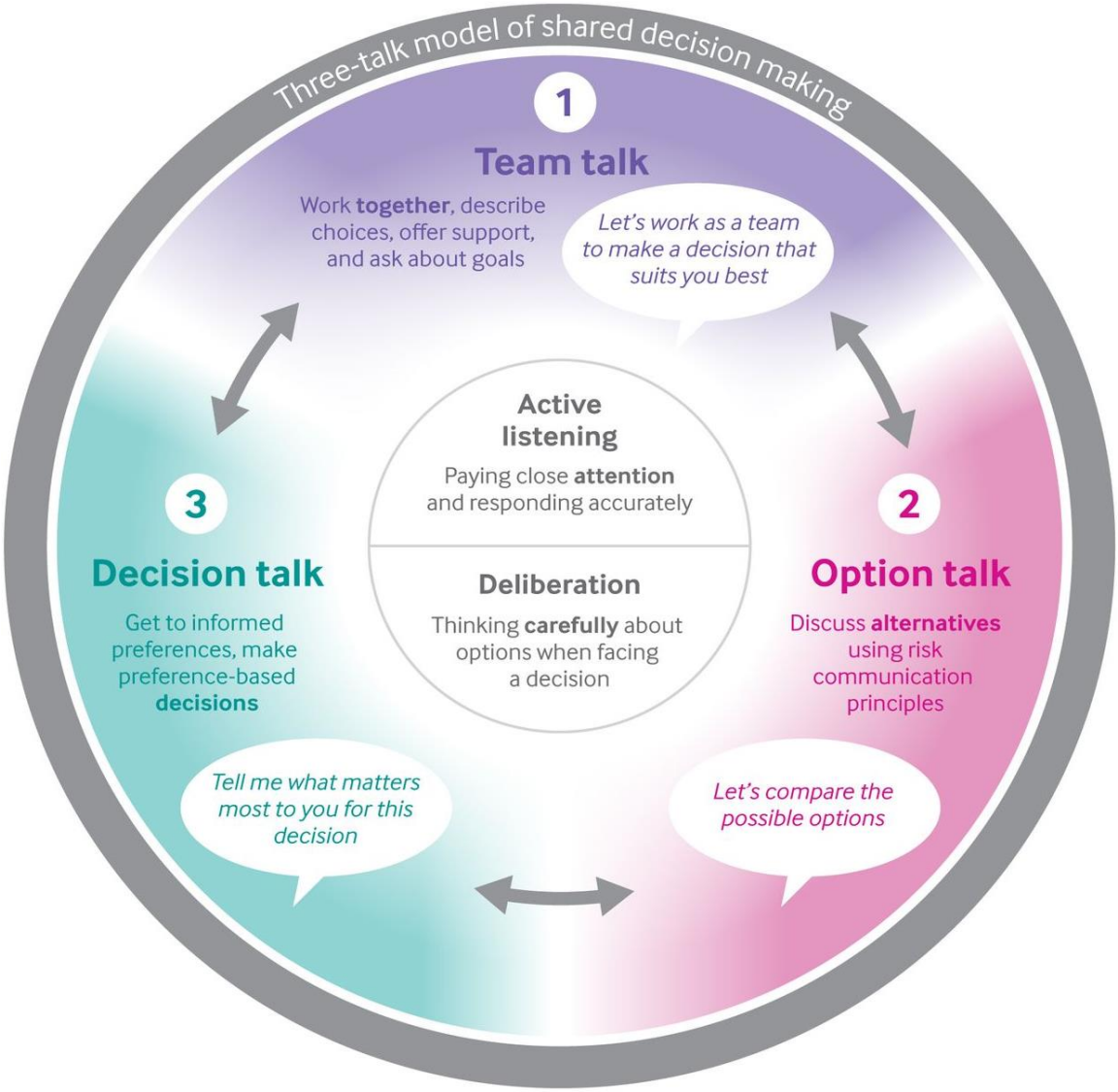
APPENDIX A

THREE-TALK MODEL OF SHARED DECISION MAKING

Figure 1

Three-Talk Model of Shared Decision Making (Elwyn et al., 2017). Permission Obtained by Author



APPENDIX B

RECRUITMENT FLYER

Seeking Your Help for a Study about
Discharge from the Emergency Room

A nursing research student from the University of North Carolina, Greensboro is interested in your discharge experience from the emergency room. You can be in this study if you are:

- 65 years of age or older
- Have been discharged from the emergency room to home, a skilled nursing facility or an assisted living placement.

Being in the study involves a 30- to 45-minute telephone interview. I would like to talk to you about your experience with your discharge plan. Participation is voluntary and strictly confidential. To learn more about the study, please call me at XXX or email me at klvalche@uncg.edu**.**
If you choose to participate you will receive a $25 Visa gift card.

APPENDIX C

RECRUITMENT SCRIPT

Hello, my name is Karen Valcheff, from the University of North Carolina, Greensboro. Thank you for calling me about the study I am conducting to learn more about patients' experience with their discharge from the emergency department. I understand that you recently received care in the emergency room at [name] Hospital. The purpose of this study, Older Adults' Perceptions of Disposition Decisions from the Emergency Department is to ask about your experience with your discharge from the emergency department and determine how involved you were with the process.

Your participation would involve a 30- to 45-minute phone interview with me. Only by talking with patients such as yourself can we understand how we can improve the discharge process for older adults and provide a smooth transition back to your home.

If you are interested in learning more about the study, I have an Information Sheet that I will read to you with the complete details. Read the sheet.

Do you have any questions? Do you agree to participate in the study? If so, I would like to proceed with the interview at this time. If you would like to be in the study, but don't have ½ hour now, I would like to set up time that is better for you.

APPENDIX D

IRB INFORMATION SHEET

Project Title: Older Adults' Perceptions of Disposition Decisions from the Emergency Department
Principal Investigator: Karen L. Valcheff, RN, MSN
Faculty Advisor: Nancy Hoffart, RN, PhD

What is this all about?

I am asking you to participate in this research study because I am interested in learning how older patients are involved in making decisions about their discharge from an emergency room. Because you were just seen at the emergency department at XX Hospital you have recent experience with this discharge process. This research project will require about 30 – 45-minutes of your time to participate in a telephone interview with me. Your participation in this research is voluntary.

How will this negatively affect me?

Other than the time you would be involved in the interview, there are no foreseeable risks from being in this study.

What do I get out of this research project?

There are no direct benefits to you as a result of participating in this study. The information gained through the study may be helpful in making improvements in how discharge from the emergency department is managed.

Will I get paid for participating?

You will receive a $25 gift card in appreciation for your time.

What about my confidentiality?

We will do everything possible to make sure that your name and the information gathered during the interview is kept confidential. All information obtained in this study is strictly confidential unless disclosure is required by law. A professional transcriptionist will transcribe the digital audio recordings, but the participant's full name will not be stated during the interview, so the transcriptionist will not be able to identify the participant. For each audiotaped interview and the respective transcript of the interview, the names of specific individual will be replaced with codes to remove personal identifiers. The transcriptionist will sign a certificate of confidentiality.

Data will be identified with codes to remove personal identifiers. The participants' identities will be kept confidential with the student researcher in a locked cabinet in the student researcher's office. The digital audio recording of the interviews and the researcher notebook will be kept in a locked cabinet in the researcher's locked room. The master list of the participants' names and addresses will also be kept in that locked file cabinet in the researcher's locked office. Only the student researcher will have a key to that locked file cabinet. The digital audio recordings will be uploaded into UNCG Box, a cloud-based secure storage space, and will be accessible only by the researcher and faculty member. Once they are uploaded to the UNCG Box and verified the interview will be erased from the tape recorder. The transcriptionist will have access during the period tape recordings are being transcribed to access the audiotapes, then upload the transcribed data into the Box folder. The recordings will be kept until the transcription is checked for accuracy and uploaded to the UNCG box. To destroy audio recordings, they will be deleted from the server using ERASER and by shredding data on paper after 5 years. Identities of individuals will be kept confidential with the lead researcher. Each participant will be assigned a code, for example, interview 1. The name of any provider or staff mentioned during the interview process will be replaced with a role. For example, nurse 1 or provider 1.

Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed although access to the recording will be limited to the researcher and her faculty advisor.

What if I do not want to be in this research study?

You do not have to be part of this project. This project is voluntary, and it is up to you to decide to participate in this research project. If you agree to participate, at any time in this project you may stop participating without penalty.

What if I have questions?

If you have questions, want more information or have suggestions, please contact Karen Valcheff at XXX or KLVALCHE@uncg.edu and/or faculty advisor Nancy Hoffart, PhD, RN at XXX or through email at nancy.hoffart@uncg.edu .
If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at (855) 251-2351.

APPENDIX E

INTERVIEW GUIDE

I would like to start by asking a few questions about you.

1. How old are you? Are you Male or Female?
2. Have you been to the ED before?
3. How many times have you been in the ED in the past year?
4. Where do you regularly go to obtain care for your health?
5. Many people your age have certain conditions such as diabetes, arthritis or a heart condition, stroke, chest pain, chronic obstructed pulmonary disease, peripheral vascular disease and or renal disease. So, which of these problems brought you to the ED?
6. Overall, how did the visit to the ER go?

I would like to talk about your recent visit to the ED at [name] hospital.

7. Was this your first emergency department visit? If not, as I ask you questions, please focus on the most recent visit.

8. Overall, how did the visit to the ER go?

Now, I want to talk with you about the part of the visit when it was being decided where you would go after you left the ED.

9. Was there a health care provider who talked with you about where you would go after you were discharged from the ED? If so, who was that person/persons?
    a. Were different choices discussed for where you would go when you left the ED? (1)
    b. Tell me what those choices were. (1)
    c. How involved were you in deciding where you would go? (3)
    d. Which of those choices did you prefer and why? (2)
    e. Did you have the opportunity to clarify any information you did not understand? (2)

10. During the discussion about your discharge, how well did you understand the information you were given?

    a. How comfortable were you with that conversation? (1)

    b. What did you like most about this conversation? (2)

    c. What, if anything, do you wish had been different? (2)

11. Tell me why you felt comfortable or uncomfortable with your discharge to home?

    a. Is there anything else that made you feel comfortable or uncomfortable)? (1)

    b. If you did not feel comfortable, what would have been a better choice for you? (1)

       Were additional choices discussed with you? (1)

12. What opportunities did you have to explain what matters most to you when it was time for you to leave the emergency room? (1)

    In this particular situation, what were the factors that mattered most to you? (1)

13. Did you feel supported when talking about what matters most to you and your goals when discharged home? (1)

14. Is there anything else you would like to tell me about the discharge decision making process during this ED visit?

Footnote: The numbers after each question represent how they align with the Three-Talk SDM components.