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Priorities of Care Among Older Adults in the Emergency Department: A Cross-sectional Study

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Abstract

Objectives—Emergency departments (EDs) are an increasingly important site of care for older adults, but little is known about the priorities of emergency care in this population. We sought to describe and rank priorities of care among older adults receiving care in the ED.

Methods—We conducted a cross-sectional study of cognitively intact patients aged 65 years and older receiving care in two U.S. EDs. Participants provided up to three open-ended responses to a single question asking what would make their ED visit successful, useful, or valuable. A literature review and patient responses were used to generate priority categories and larger metacategories. Each response was then assigned to one of the categories by independent reviewers. We report the percentage of patients identifying a priority in each category and metacategory and the relative weight of each category based on the frequency and order of priorities provided by patients.

Results—A total of 185 participants provided 351 priorities. Twenty-four categories and seven metacategories were identified. Sixty-two percent (N = 114) of participants reported at least one priority in the “evaluation, treatment, and outcomes” metacategory. Of these, the most common priorities included treatment of the medical problem (n = 37, 20%), accurate diagnosis (n = 36, 19%), competent staff and provider (n = 28, 15%), and desirable health outcome (n = 24, 13%). The second and third most common metacategories were “timely care” (n = 67, 36%), and “service” (n = 38, 21%). Nineteen patients (10%) expressed a desire to be discharged; one patient (1%) expressed a desire for admission. The ranking of weighted priorities were identical to the unweighted rank order by frequency.

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Supporting Information

The following supporting information is available in the online version of this paper:

Conclusions—Among a sample of cognitively intact older ED patients, the most common priorities were related to the accuracy and efficiency of the medical evaluation. These priorities should be considered by those attempting to improve the emergency care of older adults.

Americans aged 65 years and older made an estimated 19.5 million emergency department (ED) visits in 2010.[1] The growing role of EDs in the care of older adults has prompted efforts to modify emergency care to be responsive to the specific needs of this population through efforts including the advent of geriatric EDs, guidelines to define minimal standards for geriatric EDs,[2] and federal funding to develop methods of enhancing geriatric emergency care. A common theme across these efforts is the provision of patient-centered care and tailoring care to match patient goals, which was also recently identified as a core metric for health care progress;[3] this is particularly relevant for older adults because these individuals are more likely to have nuanced preferences of care which in some cases prioritize relief of symptoms, quality of life, and maintenance of independence over maximizing longevity.

However, the preferences and values of older adults as they pertain to emergency care are not completely understood. A recent systematic review provides insight into the preferences of older adults,[4] but neither this review nor the studies it summarizes provide information about the relative importance of these components to older adults. The purpose of this study was to identify priorities of care among older ED patients and rank these priorities based on the frequency and order with which they were identified by patients.

METHODS

Study Setting and Population

We conducted a cross-sectional study of ED patients aged 65 years and older. Participants were recruited from two U.S. EDs. Consecutive patients aged 65 years and older presenting to the ED between 9 A.M. and 9 P.M. 7 days a week were screened for enrollment. Patients were excluded if they were cognitively impaired, defined by a Six-Item Screener[5] score of 3 or less, or if they were critically ill, defined by an Emergency Severity Index triage score of 1.[6] Research assistants collected responses via a standardized in-person interview. Institutional review boards at each site approved the study. Participants verbally agreed to respond to the question but were not required to provide signed informed consent.

Data Collection

Patients were asked the following question: “Regarding today’s emergency department visit, what are the top three things that you feel would make this a successful, useful, or valuable visit for you? Please order these things for us as 1st, 2nd, and 3rd.” Responses were recorded verbatim as free text in the order identified by the patient.

Data Analysis

Previous studies have identified general themes which impact perceived quality of ED care for elderly patients.[4] We used these themes as a starting framework to analyze our data through directed qualitative content analysis.[7] Three authors (TFPM, CGI, SRG) then refined priority categories based on an examination of our sample. Each response was then

categorized by two authors (KMH, GFP) who were not involved in the selection of categories and were blinded to each other's responses. The categorized responses were reviewed by all authors and discrepancies were reconciled through consensus. Categories were grouped within larger metacategories for descriptive purposes.

The primary outcome was the unweighted percentage of patients identifying a priority in each category. Responses were also analyzed by assigning relative weights for each response based on normalization of the rank reciprocal.[8] The sums of assigned weights for all responses under each category were used to rank the categories. Data management and analyses were performed using SAS 9.2 (SAS Institute, Inc., Cary, NC).

RESULTS

Responses were obtained from 185 participants, 68 (37%) from the northeast ED and 117 (63%) from the southeast ED (Data Supplement S1, available as supporting information in the online version of this paper). The median age of participants was 75 years (interquartile range = 69–81). The majority of participants were female (60%) and non-Hispanic white (61%). The 185 participants identified 351 priorities of care. From these, 24 categories and seven metacategories were generated. For 244 (70%) of the 351 priorities, the two "coders" placed priorities in identical categories. Each priority and assigned category is provided in Data Supplement S2 (available as supporting information in the online version of this paper).

Of the 185 participants, 114 (62%) identified at least one of the reported priorities within the "evaluation, treatment, and outcomes" metacategory; 67 (36%) prioritized the "timely care"; and 38 (21%) prioritized the "service" metacategories, respectively (Table 1). Other metacategories included "physical environment" (n = 29, 16%), "communication" (n = 20, 11%), and "disposition" (n = 22, 12%). Nineteen patients (10%) prioritized being discharged home; only one patient (1%) identified hospital admission as a top priority. Very few patients (n = 2, 1%) identified the cost of care as a priority. The rank order of the normalized weighted sums for each category was the same as the rank order by frequency (Table 1).

DISCUSSION

In a sample of cognitively intact older adults, we observe that the most frequent priorities identified are appropriate treatment, accurate diagnosis, and timely care. Lower ranking priorities included competent staff and providers, desirable health outcome, time to provider evaluation, and discharge to home. Our results suggest that for cognitively intact older adults, optimizing the accuracy and efficiency of the diagnostic evaluation should be the top priority and that efforts to enhance other aspects of emergency care for older adults need to be mindful of these two fundamental and broadly identified needs.

Our findings contrast with the results of the recent systematic review on this subject, which identified timely service as one of six themes of geriatric patient-centered care but did not identify accurate diagnosis or appropriate treatment.[4] Our single open-ended question may have been an advantage as it minimized the potential for interviewers to influence patients'

thoughts on the subject. This is important because what health care providers think patients value or should value and what patients actually value may differ.[9]

One possible tension in geriatric emergency care suggested by our results is between accurate and efficient assessments and providing comfort and amenities. This tension was summarized and resolved in an observation by Al Sacchetti: “What’s the best outcome for the patient? I don’t miss your diagnosis, I treat you appropriately, I treat you quickly and you have a good outcome. Or, I miss all of those things, but son of a gun we look like the Four Seasons. There’s nothing that says you can’t do both.”[10] Another tension that is more difficult to resolve is between efficient care and conducting comprehensive geriatric assessments or supporting care transitions. Finally, not all patient priorities can or should be addressed in the ED. For example, many patients stated they wanted to “find out what’s wrong.” For some patient complaints (e.g., weakness, abdominal pain) emergency care must, by necessity, focus on excluding acute or life-threatening causes and will not answer the question of what’s wrong. Patient priorities can serve as a guide to optimizing ED care for older adults, but emergency physicians must use their judgment. Collectively, these tensions point to the need for a tailored approach: some older patients can be treated in a manner similar to younger patients, while others require more thorough and time-intensive evaluation.

This study has several limitations. We interviewed patients only once during their ED visit without restricting when during the visit the interview occurred. Patient priorities almost certainly evolve over the course of the visit. While our open-ended approach has the advantage of exploring patient priorities in an unbiased manner, it does not allow us to estimate the percentage of patients who care about specific priorities. Although we rank priorities within our sample, the rankings presented may or may not represent rankings of older adults in U.S. EDs due to the limited sampling methods (only two EDs) and open-ended approach. We also limited patient responses to three priorities. Allowing patients to describe lesser priorities may have revealed other themes or influenced aggregate ranking of priorities. Additionally, we assigned weights to priorities without patient input, and some patients may have weighted their preferences differently than the assigned weights. Fourteen patients prioritized pain treatment, but we did not ask these patients to describe their pain treatment goals, which may vary considerably between patients. Additionally, patient priorities may be different between ED patients who are likely to be discharged and those likely to be admitted and patients enrolled from 9 P.M. to 9 A.M. Related, the number of patients enrolled is small relative to the number who received care during the enrollment period. Finally, the study was conducted at two academic EDs in the eastern United States. Patient preferences in regard to medical care may be different in other regions or countries. Future research asking patients at a larger number of EDs to rank priorities identified in this work would provide more additional information on care priorities in this population.

CONCLUSIONS

Among a sample of cognitively intact older adults receiving care at academic EDs in the southeast and northeast United States, patients most often prioritized a directed and efficient assessment. These findings must be reconciled with efforts to screen older adults for

common and important problems and suggest that brief or targeted screening may be most consistent with patient preferences. Optimizing the quality of emergency care for older adults will likely benefit from attention to the essential challenge of providing appropriate, chief complaint–driven treatment in a timely manner.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Frequency of Participants (*N* = 185) Reporting a Priority Within Each Category and Metacategory and Normalized Weighted Sums Based on the Order of Priorities Reported

Priority	Frequency, N (%)	Normalized Weighted Sum
Evaluation, treatment, and outcomes	114 (62)	0.46
Accurate diagnosis	36 (19)	0.12
Treatment of medical problem	34 (18)	0.11
Desirable health outcome	28 (15)	0.09
Competent staff and provider	27 (15)	0.08
Treatment of pain	14 (8)	0.04
Coordination of care	6 (3)	0.02
Access to specialists	4 (2)	0.01
Timely care	67 (36)	0.23
Total visit time	53 (29)	0.17
Time to provider evaluation	16 (9)	0.05
Service	38 (21)	0.11
Empathetic and respectful care	37 (20)	0.11
Presence of family	1 (1)	0.003
Physical environment	29 (16)	0.08
Availability of food	12 (6)	0.03
Physical comfort, NOS*	10 (5)	0.02
Cleanliness	6 (3)	0.02
Availability of assistive resources	3 (2)	0.008
Allowance of sleep	1 (1)	0.003
Patient privacy	1 (1)	0.001
Communication	20 (11)	0.05
Communication, NOS	12 (6)	0.03
Updates on course of care	5 (3)	0.01
Explanation of diagnosis	2 (1)	0.003
Clear direction from front desk	1 (1)	0.002
Disposition	22 (12)	0.06
Discharge to home	19 (10)	0.05
Prevention of return visit	2 (1)	0.004
Admission to hospital	1 (1)	0.004
Cost of visit	2 (1)	0.004
Unable to categorize*	6 (3)	0.01

NOS = not otherwise specified.

*Priorities such as “good visit” were considered unable to be categorized.