Integrating Palliative Care into the Emergency Department

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9:30-10:45
11:15-12:30

Session Objectives

- Identify the key characteristics of the four predominant models of ED–palliative care integration observed in the United States
- Define the keys to successful adoption that these ED–palliative care models have in common
- Develop an action plan for enhancing current models of ED–palliative care delivery
Current Definition of Palliative Care

New Language:

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
Pick your curve....

Figure 1. Trajectories of dying. Reproduced with permission of Blackwell Publishing (Lunney J, Lynne J, Hogan C. Profiles of older Medicare decedents. JAGS. 2002;50:1108-1112).

Embrace the Transformational Model

Life Prolonging Care

Disease Progression

Life Prolonging Care

Palliative Care

Hospice Care

Less Ideal/Current

Ideal

Diagnosis of serious illness

Death

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The ED: A Critical Site of Care Delivery

- **The Emergency Department is the safety net for the acutely and chronically seriously ill.**
  - 116 M visits per year
    - 14 M admitted to the hospital
    - 1.1 M admitted from the nursing home
    - 1.6 M admitted to ICU
    - 139,000 died in the ED

- **As the population ages, ED visits for crisis events in the setting of serious, chronic illness are likely to increase.**

The ED: A Critical Site of Care Delivery

- Initial care trajectories are started in the ED:
  - Communication with patient/caregivers about illness/treatment options
  - Degree of medical intervention (e.g., ventilation, vasopressors, antibiotics)
  - Site of care determined (e.g., ICU, ward, home)

Yet we know that palliative care services are poorly integrated into ED culture/practice.
Processes of Care

*What do ED staff care about?*

- Providing excellent patient care
- Triage and Disposition
- Optimize and efficiently use ED resources
- Reduce ED length of stay
- Increase ED throughput
- Decrease ED boarding of admitted patients
- Increase patient/family satisfaction
- Effective Risk Management/Compliance
- Meet Core Hospital Measures (Joint Commission)

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What is Palliative Care Integration?

- The term “integration” is used to indicate the incorporation of palliative care principles into daily practice, with or without the involvement of a dedicated hospital palliative care team or inpatient palliative care unit.

1. Palliative Care Principles
   - Patient centered care focused around patient-determined goals of care
   - Focus on relief of suffering: physical, psychological, spiritual
   - Patient and family are the unit of care
   - Palliative care services are appropriate in all phases of a life threatening or limited condition.
Trends in the Aggressiveness of End-of-Life Cancer Care in the Universal Health Care System of Ontario, Canada

- N = 227,161; 1993 - 2004
- 22.4% at least 1 episode of aggressive care; every year of the study ↑ likelihood of experiencing aggressive care
- Indicators of Aggressiveness
  - ED Visits
  - Chemotherapy at End of Life
  - ICU admission
  - Rate of Hospitalization


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Trends in the Aggressiveness of End-of-Life Cancer Care in the Universal Health Care System of Ontario, Canada

- Findings (p = < 0.05)
  - ↑ ED Visits (8.6 → 10.53%)
  - ↑ Chemotherapy at End of Life (2.02% → 2.88%)
  - ↑ ICU admission (3.06% → 5.03%)
  - ↓ Rate of Hospitalization (8.5% → 7.5%)
- Risk factors: younger, rural, comorbidity, type (breast, lung, hematologic)

Journal of Clinical Oncology, April 20, 2011
The ED: A Critical Site of Care Delivery

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  - Communication with patient/caregivers about illness/treatment options
  - Degree of medical intervention (e.g. ventilation, vasopressors, antibiotics)
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Yet—we know that palliative care services are poorly integrated into ED culture/practice

Current status of Palliative Care services in the ED

- Research has demonstrated that patients with serious illness who come to the ED can expect:
  - Poorly treated pain and other symptoms
  - Poor support for the needs of family members
  - Poor communication about disease prognosis/goals
  - Inefficient resource utilization
Palliative Care Needs in the ED

- Palliative care needs are prevalent
  - 50 functionally impaired adults 65 years or older with coexisting cancer, CHF, ESLD, ESRD, ESCOPD or dementia, prevalence of symptoms:
    - physical symptoms (94%),
    - financial concerns (72%),
    - mental health issues (62%), and
    - access to care issues (58%)

Grudzen, Academic Emergency Medicine, 17 (11): 1253, 2010

Why integrate Palliative Care and Emergency Care?

1 + 1 = 3

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EDs/Palliative Care Programs

- If you have seen one, you have seen one.
  - General characteristics and philosophies are the same; specifics can vary widely

Unique Features

<table>
<thead>
<tr>
<th>Emergency Department</th>
<th>Palliative Care Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume</td>
<td>No program; desire a program</td>
</tr>
<tr>
<td>Special Patient Characteristics</td>
<td>Staffing/Resources</td>
</tr>
<tr>
<td>Cancer Center, Level 1</td>
<td>Outpatient, inpatient</td>
</tr>
<tr>
<td>Trauma Center, Rural</td>
<td>Weekday/weekend coverage</td>
</tr>
<tr>
<td>Staffing/Resources</td>
<td>Level of Development</td>
</tr>
<tr>
<td>MD’s/midlevels, ancillary services</td>
<td>Just starting/mature</td>
</tr>
<tr>
<td>Teaching hospital vs. community practice</td>
<td>Dedicated Palliative Care/Hospice Unit</td>
</tr>
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</table>
Four Observed Approaches

Vary by Intensity of Engagement of the ED
I. Traditional Consultation
II. Basic Engagement
III. Advanced Engagement
IV. ED Advanced Engagement

Observed Common Characteristics in 11 ED’s with Palliative Care Integration

<table>
<thead>
<tr>
<th>Clinical Programs</th>
<th>Descriptors</th>
<th>Focused Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Traditional Consultation</td>
<td>* ED calls when they feel they have exceeded their skills/expertise</td>
<td>None</td>
</tr>
<tr>
<td>I. Basic Integration</td>
<td>* ED and Palliative Care Program working collectively to meet goals/objectives</td>
<td>*</td>
</tr>
<tr>
<td>I. Advanced Integration</td>
<td>* ED and Palliative Care Program work together on processes and protocols, ED taking leadership in integration</td>
<td>**</td>
</tr>
<tr>
<td>I. ED Focused Advanced</td>
<td>* ED highly engaged and may direct the integration; May have ED-Palliative Medicine double boarded clinicians; ED highly engaged; can exist in the absence of a hospital palliative care consultation service</td>
<td>***</td>
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</table>
Approach 1: Traditional Consultation

Traditional Consultation

- A 40 yo male presents to the emergency department with end-staged pulmonary fibrosis. The patient comes to the emergency department for shortness of breath and progresses to respiratory failure in the ED, now on BIPAP. The patient’s wife states that the patient did not want life sustaining therapy but she now feels we should “try it”. The patient has lost decision making capacity. The ED physician feels conflicted regarding the goals and calls the palliative care service to assist with support of the wife and further discussion regarding the risks and benefits of mechanical ventilation. It is Saturday at 2pm. The palliative care service is called and says that they can see the patient on Monday.
Traditional Consultation

- Come when called…
  - Palliative care partially or fully available
  - No specific initiatives
  - Relies on the ED to recognize and identify the need for consultation

Traditional Consultation

- Common when the palliative care service is:
  - Initial formation
  - Focused on other areas in the hospital for partnership
    - Critical Care
    - Oncology
    - Cardiology
    - Hospital Medicine
  - Limited in its availability
  - Limited in its staffing
Approach 2: Basic Engagement

(engagement refers to the ED’s engagement with palliative care)

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Basic Engagement

- A 40 yo male presents to the emergency department with end-staged pulmonary fibrosis. The patient comes to the emergency department for shortness of breath and progresses to respiratory failure in the ED, now on BIPAP. The patient’s wife states that the patient did not want life sustaining therapy but she now feels we should “try it”. The patient has lost decision making capacity. The ED physician feels conflicted regarding the goals and calls the palliative care service to assist with support of the wife and further discussion regarding the risks and benefits of mechanical ventilation.

- It has been agreed upon with the Palliative Care Service that when patients present with life limiting illness and admission to the ICU for organ failure—palliative care is consulted from the ED (a.k.a clinical trigger)

- It is Saturday at 2pm. An electronic order is entered by the ED so that the PC team receives the consultation for the next available day.
Basic Engagement

- Mutually agreed upon initiatives regarding process and function
- Mutual work flow
  - Respect for ED pressures
  - Respect for PC service limitation

Basic Engagement

- May be very effective for a given system
- Infiltrates the culture of the ED as a driver for palliative care
- Positive gains
  - Earlier consultations for palliative care service
  - Emergency clinicians buy-in
    - take ownership of process and outcomes
    - part of a “greater” mission of hospital culture
Approach 3: Advanced Engagement

(engagement refers to the ED’s engagement in palliative care)

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Advanced Engagement

- A 40 yo male presents to the emergency department with end-staged pulmonary fibrosis. The patient comes to the emergency department for shortness of breath and progresses to respiratory failure in the ED, now on BIPAP. The patient’s wife states that the patient did not want life sustaining therapy but she now feels we should “try it”. The patient has lost decision making capacity. The ED physician feels conflicted regarding the goals and calls the palliative care service to assist with support of the wife and further discussion regarding the risks and benefits of mechanical ventilation.
Case

- The patient is placed on a dyspnea pathway and order set where he is administered low dose morphine for his SOB every 15 mins for SOB in addition to other supported care.

- Palliative care consultation is ordered in response to triggers: respiratory failure + terminal illness.

Advanced Engagement

- Education/QI Partnership
- Enhanced use of PC “triggers”
- ED-PC focused assessment & documentation tools
Approach 4:
ED Advanced Engagement

ED Advanced Engagement

- A 40 yo male presents to the emergency department with end-staged pulmonary fibrosis. The patient comes to the emergency department for shortness of breath and progresses to respiratory failure in the ED, now on BIPAP. The patient’s wife states that the patient did not want life sustaining therapy but she now feels we should “try it”. The patient has lost decision making capacity. The ED physician feels conflicted regarding the goals and calls the palliative care service to assist with support of the wife and further discussion regarding the risks and benefits of mechanical ventilation.
ED Advanced Engagement

- The ED Palliative Care Intervention team is activated
  - ED Social worker initiates a family meeting
- ED-Palliative Care Specialist is called to the ED to assist in the care of the patient
- ED-Palliative Care specialist works with the ED attending to arrive at comfort care only goals and arranges for transfer out of the emergency department directly to hospice care

Case 2: ED Advanced Engagement

- A 62 yo male with lung cancer presents with hypercalcemia, uncontrolled pain and vomiting. He is not able to receive more cancer directed therapy. The hospital has an onsite dedicated hospice unit.
- The emergency physician in consultation with the oncologist determines the patient is hospice appropriate and initiates a referral to hospice.
- The patient receives hospice care from the ED directly
Demonstration: Emory Palliative Care Center

501 total ED to Hospice IPU transfers in 2011 (71 direct, 430 indirect)

- N=401/501 (80.0%) died in IPU, originating from ED
  - 51/71 direct (71.8%); 350/430 indirect (81.4%)

- Direct transfers from ED to IPU
  - **Unlikely to have PC consult**, 5.9% vs 72.3%
  - Significantly older, mean 76.5 vs 69.7 years
  - Less likely “respiratory failure” diagnosis, 9.8 vs 25.4%
  - LOS unaffected

ED Advanced Engagement

- Intense generalist palliative care in the ED
- ED-PC Trained Subspecialist
- Integrated partnership with hospital based palliative care service
Getting Started

Improving both patient care and the process of care

1. Develop a collaborative workgroup of ED and palliative care staff (if available).
   - Identify key project goals
   - Complete a SWOT analysis

2. Complete a needs assessment to define targets for improvement:
   - pain and symptom management
   - care of the imminently dying patient
   - patient centered goals of care matched to treatments
   - caregiver stress/distress
   - ED clinician palliative care attitudes/knowledge/skills
Clinical Practice Guidelines:
Self-Assessment
(Source: Clinical Practice Guidelines - Technical Assistance Resource from the IPAL-EM Project)

DOMAIN 1: STRUCTURES AND PROCESSES OF CARE

<table>
<thead>
<tr>
<th>Guideline 1.1: The ED screens patients and caregivers for palliative care needs.</th>
<th>Indicator</th>
<th>Present</th>
<th>Absent</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The ED uses explicit criteria to identify patients with unmet needs for palliative care.</td>
<td>☐</td>
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<table>
<thead>
<tr>
<th>Guideline 1.2: The ED has 24/7 access to palliative care consultative services.</th>
<th>Indicator</th>
<th>Present</th>
<th>Absent</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.1</td>
<td>My hospital has a palliative care team.</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>1.2.2</td>
<td>The ED has adequate access to palliative care services.</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>1.2.3</td>
<td>The ED consults palliative care specialists when patients have unmet palliative care needs.</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>1.2.4</td>
<td>Our hospital provides an adequate number of inpatient hospice beds.</td>
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</table>

DOMAIN 7: CARE OF THEIMMINENTLY DYING PATIENT

<table>
<thead>
<tr>
<th>Guideline 7.1: ED clinicians prognosticate (predict time and functional outcome) and communicate this information empathically to the patient and family.</th>
<th>Indicator</th>
<th>Present</th>
<th>Absent</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>We regularly prognosticate and communicate information regarding serious illness or new diagnoses empathically to the patient and family.</td>
<td>☐</td>
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</table>

<table>
<thead>
<tr>
<th>Guideline 7.2: ED clinicians use empathic and culturally sensitive communication with patients and families regarding bad/sensitive news and death disclosure.</th>
<th>Indicator</th>
<th>Present</th>
<th>Absent</th>
<th>Comment</th>
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<tbody>
<tr>
<td>7.2</td>
<td>ED staff members are skilled at delivering bad news or death disclosure.</td>
<td>☐</td>
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<thead>
<tr>
<th>Guideline 7.3: The ED has a policy and process for the option of family presence during resuscitation attempts.</th>
<th>Indicator</th>
<th>Present</th>
<th>Absent</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3.1</td>
<td>The ED allows family presence during resuscitation attempts.</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>7.3.2</td>
<td>The ED has policies addressing family presence during resuscitation.</td>
<td>☐</td>
<td>☐</td>
<td></td>
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Examples of Tools Developed by ED-Palliative Care Initiatives

- Palliative Care Triggers for Consultation
- Script for volunteers who provide bereavement follow-up
- Teaching modules for volunteers training for family support
- Comfort care package for the ED check list
- Handbook guide for nurses, ‘what to do when your patient is dying’
- Protocol for Palliative Care MD to respond to the ED for palliative extubation
- ED/Palliative Care Dashboard

Getting Started

3. Create an ED-Palliative Care Dashboard
   - Metrics/outcomes that drive quality care

4. Develop a process of patient screening to identify unmet palliative care needs

5. Develop a system to utilize specialty-level palliative care service providers when required.

6. Develop a system to fully utilize common palliative care disposition resources (e.g. home or residential hospice, inpatient palliative care)
Summary

- The ED is a key venue for providing and improving palliative care.
- Persistent deficiencies in Palliative Care cause distress for patients, families and clinicians and inefficient utilization of resources.
- An ED-Palliative Care initiative can achieve a broad range of clinical benefits and possibly cost savings.
- Tools, technical assistance, and other resources to support such an initiative are available through the IPAL-EM Project. (www.capc.org)